DOCUMENT RESUME

ED 121 526 RC 009 124

AUTHOR Duran, Ruben, Ed.; And Others
TITLE Salubridad Chicana: Su Preservacion Y Mantenimiento -- The Chicano Plan for Mental Health.
INSTITUTION Western Interstate Commission for Higher Education, Boulder, Colo. Mental Health Manpower Office.
PUB DATE 15 Mar 75
NOTE 76p.

EDRS PRICE MF-$0.83 HC-$4.67 Plus Postage
DESCRIPTORS Alcoholism; *Delivery Systems; Drug Abuse; *Evaluation Criteria; Family (Sociological Unit); *Health Needs; *Mental Health Programs; *Mexican Americans; Migrant Workers; Political Influences; Socioeconomic Influences; Urban Population
IDENTIFIERS *Chicanos

ABSTRACT

In devising the mental health plan for Chicanos, the social, economic, and political forces that adversely affect their emotional well-being must be considered. While defining mental health needs and proposing ways to meet those needs, the cultural background of the Chicano people must seriously be considered. The plan should stress the importance of strong family ties and make provision to maintain and strengthen them. The plan's principal thrust should be a mental health service system based on their cultural needs. This paper presents an overview of the social, economic, and political factors that are detrimental to the emotional well-being of Chicanos. Topics include: la familia, the urban barrio, mental health needs of migrant workers, addiction to "hard drugs" and alcoholism, education and the child, and legal recourse for procurement of mental health resources. Criteria for evaluating mental health delivery programs serving the Chicano communities are given. Among these are: "Does the program preserve and understand the unique nature of the Chicano familia?"; "Is the indigenous Chicano community used as a source of manpower and expertise:"; "Have steps been taken to sensitize the staff to the unique values and life styles of the community residents?"; and "Has the program developed one or more service components designed to reach Chicanos in their own environment?" (NQ)

****
* Documents acquired by ERIC include many informal unpublished *
* materials not available from other sources. ERIC makes every effort *
* to obtain the best copy available. Nevertheless, items of marginal *
* reproducibility are often encountered and this affects the quality *
* of the microfiche and hardcopy reproductions ERIC makes available *
* via the ERIC Document Reproduction Service (EDRS). EDRS is not *
* responsible for the quality of the original document. Reproductions *
* supplied by EDRS are the best that can be made from the original. *
****

ED121526

SALUBRIDAD CHICANA: SU PRESERVACIÓN Y MANTENIMIENTO

THE CHICANO PLAN FOR MENTAL HEALTH

U S DEPARTMENT OF HEALTH, EDUCATION & WELFARE
NATIONAL INSTITUTE OF EDUCATION

THIS DOCUMENT HAS BEEN REPRODUCED EXACTLY AS RECEIVED FROM THE PERSON OR ORGANIZATION ORIGINATING IT. POINTS OF VIEW OR OPINIONS STATED DO NOT NECESSARILY REPRESENT OFFICIAL NATIONAL INSTITUTE OF EDUCATION POSITION OR POLICY

APR 1976
ERIC/CRESS
RECEIVED

RC009124

PRÓLOGO

El contenido de este plan de salubridad para nuestra raza fue el resultado de una multiplicidad de conferencias y contribuciones de muchisimos hermanos y hermanas de Aztlan.

La idea de desarrollar el plan dio vida en el otoño de 1969 cuando los Srs. Paul Sanchez y Luis Medina le conversaron al Sr. Stan Boucher de WICHE a tal respeto. El Sr. Boucher respondió con interes ávido y rápidamente se iniciaron planes para desarrollár un modelo de salubridad.

Todos aquellos que han tenido la oportunidad de participar en este esfuerzo no pronto olvidarán las experiencias y horas de labor que se llevaron acabo en Los Angeles, Cd. Salt Lake, Albuquerque, Seattle, Las Vegas, Tucson, Mt. Angel, Boulder, y Peaceful Valley. Tampoco se olvidarán los vínculos de la raza y los sentimientos de lealdad que se demonstraron entre los socios de la familia Chicana, los cuál descifran que cuando se hiere o se abusa cualquier hermano, responde toda la comunidad al agravio.

Esperamos con mucha confianza que nuestros esfuerzas no serán en vano, y que todos aquellos que lean estas paginas apoyen la filosofia de este plan.

Por fin, deseamos elogia los esfuerzos, asi como las contribuciones, de todos aquellos que perecieron a mediadas de nuestra lucha: Leo Romero, Elias Chico, Toby Maes, Rubel Lucero y que en paz descansen.

SALUBRIDAD CHICANA:
SU PRESERVACIÓN Y MANTENIMIENTO

THE CHICANO PLAN FOR MENTAL HEALTH

SCRIBES:

La Familia ..... Dr. Rubén Durán

Addictions:
Drug Abuse..... Maria Perez

Addictions:
Alcoholism ..... Alicia Noriega

The Urban Barrio ..... Efraím Lugo

Migrant Workers ..... Ricardo Ontiveros

Education and the Child .. Karol Pike

FINAL EDITING: Dr. Rubén Durán

Chairperson, Final Implementation Committee
Elsie Sánchez

ACKNOWLEDGMENTS:

For Some Few Among The Many

As can be clearly seen in "Notes on Process" (Appendix A), this plan emerges from the work, scattered over a period of four years, of some 400 people. We need, however, to thank some of our familia for special efforts and unusual dedication.

First, there is Dr. Rubén Durán, the final editor, whom we thank for his sensitivity, commitment, and long hours of work—even to the point of carrying our various manuscripts with him to Mexico so he could devote the evenings and stolen early morning hours of an otherwise much less complicated visit toward putting our work in final form for us. And then we must thank his wife, Rita G. Durán, for her painstaking work in wading through reams of handwritten notes in order to type the final manuscript.

We owe, next, a profound debt of gratitude to Dr. Arnoldo Solis, M.D., for challenging and helping to sensitize us with regard to our indígenismo. We believe the concepts he and his Bay Area colleagues are developing on this aspect of our being are deep, pervasive, fundamental.

We must certainly record our thanks to Eloy Apodaca, who not only chaired many of our organizational meetings and developed the groundwork for the Las Vegas Conference but also personally recruited many of the key contributors to this plan.

Finally, we would like to thank Narciso Aleman of Texas for initially suggesting that developing a Chicano plan for mental health would be a worthwhile task for us; Ignacio Rodriguez for believing in us and struggling against sometimes mountainous odds to retain the money necessary for this publication; and Stan Boucher, who in spirit has shown himself a member of the familia in somehow finding the means from various agencies for us to continue our work and to publish our plan.

Members, Final Editorial Committee:

Elsie Sánchez, Dallas, Texas
Luis Medina, Boulder, Colorado
Efraím Lugo, San Jose, California
Ricardo Ontiveros, Walnut Creek, California
Victor Padilla, Albuquerque, New Mexico
Rubén Durán, Pullman, Washington
Javier Saenz, Salt Lake City, Utah
Alicia Noriega, Los Angeles, California

Denver, Colorado
March 15, 1975

TABLE OF CONTENTS

PRÓLOGO

ACKNOWLEDGMENTS II

FOREWORD IV

CHAPTER

1. LA FAMILIA 1

2. THE URBAN BARRIO 5

- Chicanos in the Urban-Industrial Setting 5
- Housing 6
- Employment 6
- Education 6
- Law Enforcement 7
- Social Welfare, Public Services 7
- Mental Health 7
- Acculturation 9

3. MENTAL HEALTH NEEDS OF MIGRANT WORKERS 11

- Statement of the Problem 11
- Chicanos Defined Along Socio-Cultural Lines 11
- Training Programs Consonant with the Principles of Chicanismo 14
- General Health Status and Care-Seeking Patterns of Migrant Workers 16
- Health Insurance 16

4. ADDICTIONS: "HARD DRUGS" 19

- An Overview of Drug Abuse 19
- Drug Use Patterns 20
- General Recommendations 23

5. ADDICTIONS: ALCOHOLISM 25

6. EDUCATION AND THE CHILD 35

- Historical Perspective 35
- Educational Plan 38

7. LEGAL RECOURSE FOR PROCUREMENT OF MENTAL HEALTH RESOURCES 41

8. SUMMARY

- A. Criteria for Evaluating Services 45
- B. Some Areas for Future Action 46

APPENDIX A. Notes on Process 49

APPENDIX B. Master Participant List 55

FOREWORD

In devising this mental health plan, careful attention was given the social, economic, and political forces that adversely affect the emotional well-being of Chicanos in the United States. While defining mental health needs, and proposing ways to meet those needs, serious consideration also was given the cultural background of the Chicano people. In fact, there was early agreement among the large number of people who contributed to the plan that it would of necessity be structured along cultural lines. In this regard, the plan is unique, although some of the recommendations might have been made for people of varied ethnicity. Chicanos, for example, derive great emotional sustenance as members of nuclear and/or extended families. Accordingly, the plan stresses the importance of strong family ties and makes provision to maintain and strengthen them. The same may be said of other ethnic groups, e.g., Asians and Native Americans, who also nurture the concept of strong family ties.

Certain cultural characteristics of the Chicano people are emphasized to demonstrate the logic in the various recommendations set forth in the plan. Preschool Chicano children are a case in point; many of them neither speak nor understand English. Given that Spanish is a first language for many of our people, Chicano children in their formative years cannot be expected to cope adequately with the English language without bilingual educational programs, any more than Anglo children should be expected to cope with Spanish without special training. In recommending a bilingual system of education, we hope to eliminate, once and for all, the emotional trauma Chicano children suffer and the subsequent impediment to learning they sustain when they are suddenly thrust into a classroom totally lacking in cultural identity. This example illustrates that the threat to mental health of Chicanos may, and often does, begin during childhood.

We believe, moreover, that the multiplicity of factors that affect the emotional well-being of Chicanos are often directly or indirectly related to racism. Without doubt, racism has served to deny Chicanos numerous opportunities taken for granted by Anglos. Educational opportunities are one of the most important examples. Today, even the unsophisticated realize that Chicanos are poor because they are undereducated and undereducated because they are poor. The fact that Chicanos continue to live in poverty in an affluent society that purports to extend equal opportunities to all citizens is frustrating and hardly conducive to good mental health.

We would add that apathy, cynicism, anger, and frustration are predictable and universal responses to chronic poverty. Poverty transcends cultural lines but inevitably affects the mental health of its victims, be they Chicanos, Blacks, Native Americans, or poor whites. In recent times, corruption in American politics likewise has served to anger and frustrate the American electorate, leaving in its wake cynicism and political apathy. The current political disenchantment that millions of Americans are experiencing serves to help us understand why Chicanos and other Third World people tend to look with disdain on the concept of the American dream.

We have selected for general discussion with a minimum of rhetoric problem areas that we believe are detrimental to the mental health of Chicanos in one way or another. In doing so, we have solicited the advice and counsel of professional mental health care personnel, community people, and others interested in promoting mental health services. In reading the material, it is important to distinguish between cause and effect. The section "Addictions," for example, points out that the poor, unlike the affluent, may, out of frustration, turn to drugs and/or alcohol to "forget" the reality of racial discrimination, unemployment, dilapidated housing, and a myriad of other problems from which they see no escape.

Unavoidably, there is some overlapping of subject matter, although we have tried to minimize duplication. The section dealing with the mental health needs of migrant workers discusses problems similar to those that barrio residents face in terms of education, housing, employment, welfare, etc. As set forth here, the principal thrust of the plan has been to show the rationale in calling for a mental health service system for the Chicano people, on the basis of cultural needs. We hope we have succeeded in doing so.

Elsie Sánchez, *Chairperson*
Boulder, Colorado
1975

CHAPTER 1
LA FAMILIA

As a Chicano social institution, *el concepto de la familia* has had a profound and positive influence on the thinking and life style of Chicanos for centuries. To be a member of a familia is to have that all-important feeling of belonging, secure psychologically in the knowledge that parents, brothers, and sisters, as well as members of the extended family, are equally concerned with one's physical and emotional well-being. The interrelationship between mental well-being and belonging to a familia is self-evident in that for centuries the familia has been the cohesive and protective force of the Chicano culture. Indeed, it is safe to say that the familia has been the crucial controlling factor in preserving the Chicano culture in the face of tremendous acculturation pressures.

In referring to the familia, one is essentially alluding to the culture itself; thus, Chicanos from 13 western states participating in four conferences sponsored by WICHE in 1972, 1973, 1974, and 1975 unanimously agreed that health delivery services to Chicanos in the United States would have to be implemented along cultural lines in order to be effective.

In devising the plan, we hope to have laid to permanent rest the notion that as Chicanos we are beset with mental problems because we do not conform to established cultural norms perceived by Anglos. Early in our thinking, the necessity to define mental health from a Chicano point of view became obvious. Because our people are frequently torn between two cultures, we contend that acculturation is one of our most serious problems, because sooner or later it leads to a negative state of mental health. Conversely, adherence to the Chicano culture reflects a *positive* state of mental health.

The relative state of mental health among Chicanos has been the subject of controversy largely because we have often been judged by Anglo Saxon ethos. Historically, we have been perceived as decadent, lazy, non-future oriented, happy-go-lucky, etc. Implicit in these perceptions is the notion that mental problems among Chicanos are related to our behavior and our cultural values. Precisely for that reason we have deemed it imperative in developing our position paper to reflect as accurately as possible the current thinking of contemporary Chicanos and their families. Time was, for example, when people of varied ethnicity were convinced that success in white middle-class America demanded assimilation. With the renaissance in ethnic pride in America, particularly among Third World people, much of this thinking has changed. Indeed, resistance to assimilative pressures (still regarded by many Anglos as a form of deviancy) is increasing, not only among Chicanos, but among other minorities as well. Nevertheless, retention of our customs, which are part of our Mexican heritage, and the degree to which we cling to them will very likely continue to be misconstrued and used as an index of deviancy by Anglo psychologists and sociologists.

Ironically, our propensity to preserve our culture, with its attendant life style, language, and customs, serves to emphasize this point: In recent years, psychologists at the University of California concluded that thousands of Chicano children are mentally retarded; but it is common knowledge in the Chicano communities that in these studies culturally biased tests were used to test the intelligence of children in their formative years, many of whom could not relate to the Anglo culture or even understand the English language adequately. These "studies," have been rightfully assailed by Chicanos and need not be discussed here, except to say that they are exasperating and have served to perpetuate the myth that most of our problems are self-imposed and can be corrected by assimilation. In devising our plan for delivery of health services, we have carefully guarded against dignifying these and similar allegations lest we abrogate our right to determine when—or even if—we are sick. In effect, we contend that belonging to a familia and espousing the culture of our ancestors is to be healthy in both mind and spirit!

La Familia— still the core of Chicano culture. Ties between generations are still loving, close, no matter how "extenuated" the Chicano family may have become under recent onslaughts. (Photo by Clyde Archibeque)

Clearly, then, mental health problems in our community must be approached from a cultural point of view; therapeutic programs to correct them must also be consonant with our cultural values. Moreover, in assessing mental health in our communities, we must emphasize the point that our determination to preserve the Chicano culture against tremendous alien pressures reflects a very positive attitude on the part of our people, from both a social and psychological point of view.

To promote good mental health, we feel that the family as a social institution in the community must be strengthened, not only because of the role it has played in preserving the culture, but also because it has served traditionally as a source of emotional strength and well-being. Accordingly, we have stressed the need for counseling services to be made available in the center(s) in order to reaffirm family ties, recognizing that the concept of familia embodies much of the Chicano culture, and is, in effect, an inextricable part of it.

For years the Chicano family with all of its nuances has been the subject of considerable discussion and speculation among Anglo social scientists. Many studies have touched on hierarchical aspects and the role various members play in the nuclear and extended family, as well as its pros and cons as a social institution in the community. Inevitably, modifications in attitude have changed somewhat the structure of the family during the last generation (e.g., parents play more equitable roles in governance of the family, and women are playing more significant parts in community affairs than they were a generation ago). Nevertheless, *most* of the traditional values that characterize the Chicano family have resisted significant change: we continue to speak the Spanish language, recognizing it as our mother tongue; we continue to base the family structure on respect for parents by children; we continue to nurture ties between relatives in extended and nuclear families; we continued to venerate the aged and provide for the infirm without committing them to institutions; we continue to maintain discipline more by invoking mercy and compassion than by punitive measures; and finally, we continue to be charitable in our attitude toward others and to be Catholic in terms of our mores.

In recent times, however, these and other cultural values have been questioned and even flouted by individuals in various stages of acculturation. Thus, young men and women on the outer fringes of acculturation may aspire before marriage to leave home and "be on their own," or marriage may be looked upon as outmoded and obsolete. These examples are sufficient to illustrate that acculturation poses one of the most serious threats to the Chicano culture.

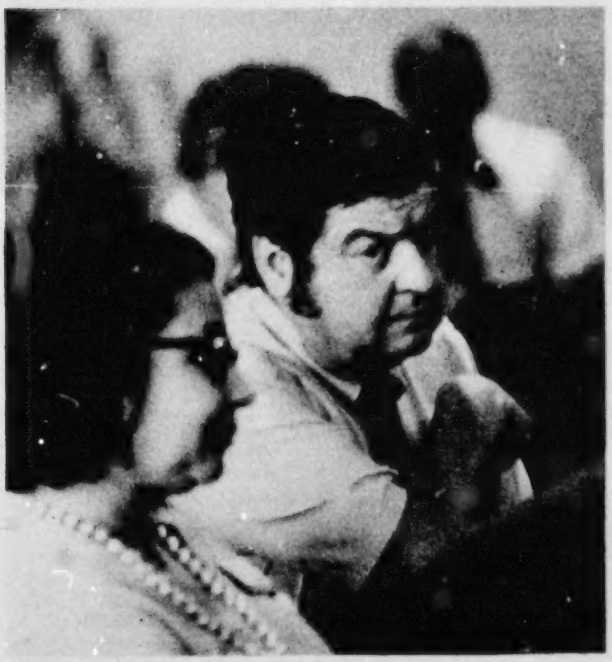
In terms of promoting mental well-being, then, preservation of the family with all of its cultural values is of obvious importance and has been stressed in the plan. We know, for example, that despite unprecedented affluence, mental depression is common among Anglos, although it is rare among Chicanos, most of whom are poor. To a substantial degree, we attribute this to the emotional strength derived from belonging to a familia, whether nuclear or extended. We feel that the centers must further strengthen *el concepto de la familia* if our culture is to persevere, particularly now, when the legitimacy of the family as a social institution is under fire. We recommend that the centers provide counseling services to reinforce cultural values that have proven beneficial to our people, particularly those that strengthen the family structure. Because the integrity of the familia has in fact been seriously weakened in recent years by forces of acculturation, we have made provision for an elaborate system of counseling to help solve or ameliorate this most serious problem.

By design, much of the plan is geared to serve entire families. We recommend that staff members be individuals who have roots in the community and that all be sensitized to the cultural and social values of people in the surrounding community. We believe that in this way, the staff's efficiency and rapport with individuals and families of the community will be greatly enhanced.

In devising the plan, we have taken into consideration that Chicanos, in seeking medical attention, often react negatively to circumstances entirely acceptable to Anglos. The impersonal way of delivering health services in American hospitals, clinics, and doctors' offices is one such example: When a Chicana is asked to undress during a medical examination, she is apt to refuse or to do so reluctantly, especially if she is of middle age and the attending physician is Anglo. The present plan attempts to eliminate

or at least minimize these and other potential conflicts, which have in the past discouraged our people from seeking medical attention in Anglo clinics and hospitals.

Finally, we feel confident that the center(s) for delivering health services to Chicanos in the barrios of the United States will meet with unqualified success if administrators and staff solicit and receive the input of the people they are serving, particularly the heads of families.



Leo Romero— the only photo from all the conferences he organized and helped to lead. Leo Romero as he is remembered: concern, compassion, energy. . .

CHAPTER 2
THE URBAN BARRIO

Among the factors that seriously affect the mental health of Chicanos in the barrios are inadequate housing, unemployment, educational neglect, harassment by police, inadequate social and health care, and inadequate public assistance. Considering the social ambiance in which Chicanos live and the daily problems they face, it is easy to understand why mental health problems in the barrios are becoming increasingly serious.

Medically speaking, mental health implies

A relatively enduring state of being in which an individual has effected an integration of his instinctual drives in a way that is reasonably satisfying to himself as reflected in his zest for living and his feeling of self-realization. For most individuals, mental health also implies a large degree of adjustment to the social environment as indicated by the satisfaction derived from their interpersonal relationships as well as their achievements.[1]

Caplan and Caplan have defined mental health as "the potential of a person to solve his problems in a reality-based way within the framework of his traditions and culture."[2] We here define mental health as the development of a positive self-image and the maintenance of one's esteem.

Regardless of the definition for mental health, be it one or a combination of those alluded to above, Chicanos are not apt to enjoy mental health as long as social and economic factors are pitted against them.

This section of the mental health plan presents an overview of social, economic, and political factors that are detrimental to the emotional well-being of Chicanos; in addition, it focuses on aspects that should help us formulate a more relevant and meaningful model for mental health than those currently in use in the urban barrio.

Chicanos in the Urban Industrial Setting

Contrary to concepts that stereotype them, Chicanos historically have consistently striven for a better way of life. In the process, many have migrated to urban areas of the United States, where, ostensibly, a better life beckoned and chances for success seemed best. This is also evident in the flow of Mexican emigrants who likewise have settled in urban industrial areas.

Whereas for decades most Chicanos and Mexican emigrants lived in rural areas where stoop labor in agriculture was available, in recent times both have settled in large numbers in urban industrial areas. In fact, at the present time it is estimated that as many as 80 percent of all Chicanos and Mexican emigrants live in barrios near or adjacent to urban industrial areas.

The steady migration of Chicanos and Mexican emigrants to urban industrial areas of the United States has had a profound affect on barrio residents. As the number of arrivals has increased, so has competition for jobs and housing. The dearth of jobs and adequate housing, both of which continue to worsen, have served to further frustrate barrio people, particularly the young.

In addition, the generally crowded and understaffed schools in the barrios have been forced to accept more and more students from rural areas, as well as those arriving from Mexico. This influx of people to barrios from rural areas has compounded staffing problems and strained physical facilities in barrio schools to a maximum. Moreover, overworked teachers are made to assume additional work loads, insensitive school administrators fail to meet the needs of Chicano students, and those having difficulty with their studies fall further behind and ultimately drop out of school. Needless to say, all of these factors perpetuate the cycle of poverty and affect the mental health of barrio residents.

[1] *Blakiston's Pocket Medical Dictionary*, 3rd ed. (New York: McGraw-Hill Book Co., 1973), p. 476.

[2] Gerald Caplan and Ruth Caplan, "Development of Community Psychiatry Concepts in the United States," in *Comprehensive Textbook of Psychiatry*, ed. by Alfred Freedman and Harold Kaplan (Baltimore: Williams & Wilkins, 1967).

Housing

Newcomers to urban industrial areas often find that the squalor of housing in the urban barrios matches or exceeds that of the agricultural migrant camps they left behind. Too often, the housing consists of tiny, cramped, cardboard-walled makeshift rooms; converted garages with dirt or concrete floors; or cold, damp, musty basements. These are "home" for families that more often than not are large. To add insult to injury, rents extracted from tenants are apt to be exorbitant. Studies have shown that landlords are apt to be former resident-owners eager to extract the last possible dollar from condemned properties before bulldozers level them for redevelopment.

According to Moore and Cuellar,[3] more than 33 percent of all Chicano families living in urban areas of the southwest dwell in substandard, overcrowded housing (compared to 8 percent for Anglo families). In terms of quality, there is seven times more dilapidated housing than in the Anglo community. Given that housing is one of the most basic of human needs, the handicap that Chicanos face in maintaining emotional and physical well-being is self-evident.

Employment

Although Chicanos have migrated to urban areas in search of a better life for themselves and their families, for many the move has proven disastrous. For one thing, most come to settle in urban areas without saleable skills and soon find themselves forced to accept whatever jobs are available—as dishwashers, busboys, cook's helpers, parking-lot attendants, janitors, laborers, etc. Chicanos are apt to be hired at the lowest possible level and given little opportunity for advancement.

Chicanos are forced to work at menial jobs for a variety of reasons, the major of which are "lack of education, lack of business capital, cultural dissimilarity vis-à-vis the dominant society, and the lack of prestige with which Anglos regard them. Furthermore, there is a disproportionate number of Chicanos and Mexicans employed by low-wage or marginal firms in the less profitable, nonunionized fringes of the high wage industries."[4]

[3]Joan Moore and Alfred Cuellar, *Mexican Americans* (Englewood Cliffs, N.J.: Prectice-Hall, Inc., 1970).

[4]Ibid.

Unemployment for Chicanos is roughly double the rate for Anglos and their income is less than half, though it differs in some jobs. Also, the Chicano breadwinner must stretch his income to provide for a larger number of dependents on the average, than does his Anglo counterpart.

In summary, Chicanos are hired mostly for menial, low-paying jobs with minimum wages; advancement opportunities for them are extremely limited; job security is minimal because capricious employers harass and exploit them; and they earn half of what their Anglo counterparts earn to support large families.

Education

Aside from the home, the educational system is a major socializing entity in the barrio. Although bilingual educational systems have been recently implemented for Chicano children in certain parts of the country, the Anglo system of education has traditionally ignored the needs of the Chicano child. In that Spanish-speaking children have been unable to cope or identify with it, the educational system has served to perpetuate the negative image that Anglos have of Chicanos.

Moreover, the system has served more to acculturate than to educate the Chicano child. By the time the Chicano child reaches the third or fourth grade, he is apt to be thoroughly confused as to his identity, ashamed of his culture and heritage, and no longer able—or willing—to speak his natural language. By this time, he is apt to be one or more years behind his age group in school and is not likely to ever catch up. Eventually, he will fall victim to an educational system solely responsible for his educational demise. Ironically, the system then turns around and blames the "language problem" Chicanos are purported to have and the lack of appreciation parents have for education to explain why Chicano children are not motivated. Convinced that Chicano children are "low achievers" or "slow learners," teachers and/or administrators in the public schools often shunt children by the thousands into low track classes or EMR classes to vegetate, lose all interest in school, and eventually drop out.

Unless it is changed, the system of education is certain to go on discouraging Chicano students

in great numbers, and, in the process, to contribute to one of the most shameful examples of educational neglect in the history of this country. Failure of Chicanos to get an education commensurate with their potential is clearly a needless waste of human resources.

Law Enforcement

Minorities have always known that the judicial system in this country has had a tendency to apply two standards for justice—one for them and one for the rich or affluent. With the recent exposé of wholesale corruption at high government levels by Senate investigations of the Watergate break-in, an increasing number of people have come to realize that there is, indeed, a double standard of justice in America and that it is grossly unfair to the poor.

It is common knowledge that the only institutions in this country in which Chicanos are well represented are the state and federal prisons. To a great extent, this is due to police deployment tactics. Chicanos are well aware that the concept of law and order is applied with greater zeal in barrios and ghettos than in affluent areas in which most of the residents are white. Early on, Chicanos learn that the police are their oppressors, wheras most Anglos consider police to be public servants.

Morales[5] demonstrated that the Los Angeles Police Department deploys a substantially larger number of police units in East Los Angeles, where a large number of Chicanos live, than in the nearly all-white West Valley, which is spread over an area 50 percent larger than East Los Angeles. Morales further showed that although there are approximately equal numbers of alcoholics in both areas, the incidence of arrests for both drunkenness and drunk driving in East Los Angeles is nearly seven times greater than in the white community. The explanation for this discrepancy lies in the fact that 13.5 police units are deployed in every square mile in East Los Angeles, whereas 3.5 are deployed in the West Valley. Since the incidence of major crimes is nearly equal in both areas (4.9 vs 4.8 percent), the conclusion that laws are more strictly enforced in the barrios than in the white communities is inescapable.

[5]Armando Morales, "The Impact of Class Discrimination and Racism on the Mental Health of Mexican-Americans," in *Mexican-American Mental Health Issues*, ed. by Stanley W. Boucher (Boulder, Colorado: WICHE, 1970), p. 34.

So long as large numbers of police units are deployed in the barrios and law enforcement is more strictly applied there than in white communities, friction and resentment will continue to develop between the Chicano community and police. A situation such as this is hardly conducive to mental health, even without the added problems of police harassment and brutality, so common in all areas where Chicanos and other minorities live.

Social Welfare and Public Services

At one time or another, most of the poor have had to confront various public agencies in seeking social services, e.g., welfare assistance, family planning, employment, and counseling. Each agency tends to be governed by a different set of regulations and procedural policies that are confusing to Chicanos, many of whom speak little or no English. Also, each agency has myriad forms that applicants must complete to "establish eligibility and need." Given that each agency is the sole judge in assessing need and determining eligibility, applicants tend to feel that they are at the mercy of the agency. Moreover, the bureaucracy and red tape through which applicants must wade are long and tedious, and they discourage people from applying for help until they are desperate.

Even under the best of circumstances, soliciting services from public agencies tends to be a demeaning experience, particularly for Chicanos who view Anglo institutions with fear and apprehension and understand little of the bureaucratic process. The ordeal of having to prove need for public assistance is a difficult one for people in general. To be subjected to intimate questioning by insensitive and often officious social workers is a dehumanizing experience for the poor. As one man put it, you are asked five dollars worth of questions but get only fifty cents worth of help.

Mental Health

Chicanos have fared poorly in dealing with mental health programs in the major cities of the United States. Mental health agencies established to provide services to the general public have been generally unsuccessful where Chicanos are concerned. Moreover, mental health specialists have continued to employ methods proven ineffective in treating Chicanos and other

minorities. Clearly, there is need to alert the mental health profession to the need for change.

As Torrey put it:

Psychiatric services in the United States are sharply bound by both class and cultural values. . . . The vast majority of service, delivered by highly trained professionals stressing insight and autonomy, evolved to meet the needs of upper-class America and are vaguely assumed to emanate from God-given principles. The resulting lack of class and cultural perspective produces services for minority groups that, when they exist at all, are both illogical and irrelevant . . . . No real effort has been made to conceptualize logical and relevant psychiatric services for them. They must make do with what services are available as decreed by the majority culture and majority class.[5]

It is obvious that Chicanos and other minorities are expected to "make do" with a system of mental health services that fails to take into consideration class and cultural values. To expect such a system to succeed with Chicanos and other minorities is entirely illogical.

Reisman threw additional light on the problem:

In the past decade, the social and behavioral sciences have accumulated considerable research data displaying one of the serious paradoxes of our generation. While we are becoming increasingly aware of the mental health problems of the lower socio-economic segments of our society, we have all recognized and documented the inadequacy of the mental health services available to them. The lack of knowledge and skill to engage the poor in treatment further adds to their continually increasing dilemma. The low-income person is bombarded with pleas and advice from the mass media, the schools, and the professional community to seek help with family and individual emotional problems. But he finds, after making a difficult decision to use such services, long waiting lists or costs for private care beyond his means. This, in addition to the requirements of agency bureaucratic organization, and aspects of the treatment process itself, leads to early withdrawal even after the patient's energies have been mobilized to do something about the problem.[6]

Given the situation, Chicanos are understandably reluctant to solicit mental health services from Anglo institutions they view with suspicion. When they do seek help, their suspicions are apt to be confirmed when they must go through a series of processing sessions to help them "get well," and they must deal with people who understand little or nothing of their cultural values. Nor can Chicanos be expected to accept, a priori, that they are ill by Anglo standards of mental health. In this regard, Chicanos are prone to say, *"Estamos necesitados, no locos."*

The entire mental health routine is a very mysterious and perplexing one for most Chicanos, who view mental health practitioners as very "curious" and strange people with their questions and condescending manners. For example, on the matter of labeling, Romano commented:

The categories that one encounters in the field of mental health, such words as deviant, irrational, pathological, dysfunctional, neurotic, do not exist in the barrio . . . . If such words are not used in the barrio, does that mean that Chicanos behave differently, so that there is no need for these words? . . . There is certain behavior that could be labeled "not acceptable" in the barrio. What are the words used to describe this? And this is crucial, the labels you use to describe human beings are very crucial indeed, because everybody knows that in medicine the label denotes the treatment. So what have you in the barrio? You have words like, "está loquito"; "es sonso"; even "menso"; "está zafado." What are the differences between barrio terms and technical terms? The technical terms like "dysfunctional," "irrational," "pathological" are separating terms. . . . But the counterparts in the barrio are not separating terms; they are descriptive terms through which a whole series of incorporating mechanisms take place . . . . You don't have a duality—rational/irrational, functional/dysfunctional.[7]

Romano's insight helps us to see that instead of providing adequate mental health services, extant systems are adding to the mental health problems of Chicanos. It is small wonder indeed that Chicanos do not use mental health services patterned after the Anglo model.

Johnson further elaborated on this point:

The ineffectiveness of current therapeutic strategies is seen in studies by Yamamoto et al., 1968, . . . Mexican-Americans are not only reluctant to utilize existing mental health services, but are often discharged or seen for minimal supportive psychotherapy. Lack of awareness and sensitivity to

[5]E. Fuller Torrey, "Psychiatric Services for Mexican Americans" (unpublished paper, Department of Psychiatry, Stanford Medical Center, Stanford University, August 26, 1968), p. 3.

[6]Frank Reisman, Jerohm Cohn, and Arthur Pearl, "Introduction," in *Mental Health of the Poor* (New York, The Free Press, 1964).

[7]Octavio I. Romano-V., "The Impact of the Mental Health of Anglo Social Institutions upon the Mexican-American," in *Mexican-American Mental Health Issues: Present Realities and Future Strategies*, ed. by Stanley W. Boucher (Boulder, Colo.: WICHE, 1970), p. 42-43.

minority group members' values and expectations were seen as part of the underlying ineffectiveness of the therapeutic intervention techniques utilized.[8]

It is not enough to bring mental health centers to the barrios and staff them with Spanish-speaking Chicano mental health practitioners or for the barrio community to give input to or control mental health centers in the barrios, if the net result is nothing more than substitution of brown faces for white, and Spanish for English. The changes needed are far more basic than provision of mental health services by Chicano practitioners who can speak Spanish to their clients. The continued use of the medical model in diagnosing mental health needs of Chicanos is the first issue that must be examined. Johnson further added,

The present medical model approach to therapy, a sickness model which is morally and spiritually bankrupt, with its emphasis on diagnosis, specifications, and artificial . . . neutrality, tends to fragment and destroy the Mexican American's self-actualization and self-transcendental notions of living.[9]

Sanchez stated,

It is . . . obvious that . . . application of the psychoanalytic model to a culture whose underlying philosophy is humanism will result in a high incidence of mental illness as well as a pronounced severity among the Chicano population.[10]

The use and application of the psychotherapeutic medical model to diagnose and treat Chicanos has been the main issue of controversy, although it has gone unrecognized until recently. Anglo mental health services have always been irrelevant for Chicanos and will continue to be so as long as the same model is used. Until recently, researchers studying the lack of use of mental health facilities by Chicanos concluded that Chicanos could not afford to pay the required fees, facilities were too distant and uninviting, and the language factor militated against their use. No one looked at the irrelevancy of the methods of diagnosis and treatment.

Sanchez met the issue head on:

The major assumption in studies of services and severity of mental illness . . . is that the psychoanalytical model works with the Chicano community. A second assumption is that the Chicano community perceives mental illness in exactly the same way that the dominant society perceives mental illness. It must be noted that the psychoanalytic model has its basis in the sociological assimilation model which has been operative unilaterally vis à vis the Chicano community.[11]

Acculturation

Some of the most serious problems that must be solved if Chicanos are to enjoy mental health are those stemming from acculturation. Ironically, the psychoanalytical approach and/or the sociological assimilation models, thought by Anglo practitioners to hold the answers to mental health problems, have confused, befuddled, and sometimes embittered minorities who were led to believe that in assimilation lies the key to social acceptance and the American dream. Moreover, pressures of the dominant society and the frustration of having to contend with myriad socioeconomic problems have at one time or another driven Chicanos to mental health practitioners who advocate the melting-pot theory. This has put Chicanos in the untenable position of seeking help from agencies that see assimilation as the answer to mental health problems. In this regard Sanchez added,

Agencies and personnel still operate on the assumption that assimilation into the melting pot is the goal. Moreover, agencies are always assumed to be non-causal. Politically, the medical model lends itself well to retention of the colonialist posture, for it establishes the definer and the defined, the manipulator and the manipulated.

In the final analysis, the Chicano predicament is caused by social, political, and economic conditions; to force these conditions into the inner psyche . . . is detrimental to and destructive of a distrinctive way of life. The result, obviously, is an intensification of social problems and "mental" problems, stress and strains in the life style of the Chicano community. It makes little sense to talk about mental health without social health. To treat the problems and neglect the issues is a disservice to the Chicano community and to society.[12]

In order to assess mental health needs of the Chicano people, it is necessary to understand the world in which Chicanos live, including their socioeconomic, political, and philosopic points of

[8]Henry S. Johnson, "Mental Health Needs of Mexican Americans," paper presented to the Regional Training Program to Serve the Bilingual/Bicultural Exceptional Child, Montal Educational Associates, February, 1972.

[9]Ibid.

[10]Armand Sanchez, "The Definers and the Defined: A Mental Health Issue," *El Grito*, Vol. IV, No. 4, Summer 1971 (Berkeley, Calif.: Quinto Sol Publications).

[11]Ibid.

[12]Ibid.

view. Clearly, the philosophic point of view, as well as the culture, of Chicanos must be fully understood and accepted before meaningful mental health services can be made available to them. Again, Sanchez has provided us with the concept:

Mental health for the Chicano community consists in the full awareness of itself as an ontological entity with its philosophy of man, nature and the universe. A corollary of the full awareness is the full realization of its power of self-determination. Hence, it is imperative for Chicanos to sustain and/or enlarge their human interrelational community services. A "system" already exists within the Chicano community. Hence, the diagnosing and defining of mental illness is already done within the framework of the Chicano way of life . . . . A particular behavior is reflective of that community's philosophy of life. At no time have "mental health services" been developed to reflect this aspect of the Chicano barrio. Hence, "mental health" concepts must be developed out of the Chicano philosophy of life.[13]

This was put more succinctly by Johnson:

To understand the mind of the Mexican American is a necessary prerequisite to the understanding of his mental health needs vis à vis the ability to effectively treat existing emotional problems of the Mexican American.[14]

How, then, are the "mental health" needs of Chicanos to be met? What, in fact, constitutes mental illness for Chicanos, and who defines the conditions? Answers to these questions lie in the Chicano community, for Chicanos must determine the nature and extent of mental illness in their communities. In keeping with the spirit of self-determination, Chicanos also must use the existing barrio system to determine their mental health needs and all other social services as well. Mental health specialists in the barrio and others with special expertise must be employed to develop and implement a system that will address itself not only to the mental health needs of Chicanos but also to other services needed in the barrio. Johnson stated,

It is quite clear that what the Mexican American needs is not more mental health specialists in the barrio who are ill trained, but specialists who are aware of the unique psychodynamics of the Mexican American's values and attitudes.[15]

Sanchez said,

The starting point suggested for human development services is assessment of a barrio's existing total human health, for problem-solving in the Chicano community is related to the Chicano community, rather than to an agency. The health of an individual and community does not exist in a vacuum, rather, it is related not only to the total environment, but also to the other individuals and the networks of interrelationships that give life as well as . . . character to a community.

Hence, the well-being of an individual and community must be studied . . . within the barrio with its complex network of relationships, for when all is said and done, the barrio is a social institution.

It is a basic concept of human well-being that a person is much healthier if he accepts what he is and values himself and his background. Hence . . . it is not basically a problem of non-utilization of "mental health" services . . . by Chicanos; rather, the non-utilization is the result of failure of "mental health" agencies to acknowledge and accept the Chicano way of life as a valid, viable, and dynamic expression of a philosophy of man and his existence, together with a view of nature and the universe which . . . must form the framework for a definition of well-being for Chicanos.

. . . I would add that the major premise on which policy . . . well-being . . . must be based is that of a pluralistic society founded on mutual respect, appreciation, and understanding . . . The first problem, therefore, is to indicate the barrio way of life in its possible relation to the individual's well being.[16]

[13]Ibid.
[14]Johnson, op. cit.
[15]Ibid.
[16]Sanchez, op. cit.

CHAPTER 3
MENTAL HEALTH NEEDS OF MIGRANT WORKERS

Even those familiar with rural mental health programs seldom know firsthand the difficulties that arise in attempting to provide mental health services to migrant farm workers. This section of the mental health plan identifies some of the problems that must be solved if migrants and their families are to receive adequate mental health services. Considering that such services are inadequate for the general population, they are even more so for migrant workers. Moreover, the fact that migrants are constantly on the move and the reluctance of service agencies to help them further exacerbate the problem of providing them with mental health services.

Statement of the Problem

In order to develop a good mental health program for migrants, it is necessary to define mental health from Chicanismo perspectives and, concomitantly, to consider the unique environmental circumstances in which migrants live. While no attempt will be made here to define Chicanismo as a cultural phenomenon, suffice it to say the term implies a militant sense of brotherhood and a desire to bring about social changes to improve the lot of Chicanos.

To the extent that Chicanos assume such a posture, they differ in their cultural and social outlook from those who identify with Mexican-Americans. The latter are more prone to favor assimilation, strive for acceptance into the dominant Anglo society, or be content with the status quo. Chicanos are more apt to be concerned with the problem of maintaining and reinforcing the Chicano culture, opposing assimilation, advocating cultural pluralism, and preserving the intrinsic cultural values of Chicanismo. Finally, Chicanos are vitally concerned with the problem of improving working conditions and increasing wages for farm workers through unionization.

While it may be argued that differences in sociopolitical outlook between Chicanos and Mexican-Americans are relative, Chicanos, in terms of culture, are distinct from Mexican-Americans and, hence, warrant special consideration in developing a system of mental health services for them.

Chicanos Defined Along Sociocultural Lines

Practically speaking, Chicano is a term used to identify individuals of Mexican descent who, in one way or another, are concerned and/or involved with the social struggle to improve the lives of Spanish-speaking people. How and where the term originated is relatively unimportant. It is important to note, however, that the term Chicano identifies a group of people involved in a social struggle that is hundreds of years old and that continues today.

The following excerpt from a Department of Labor report[1] identifies Chicanos in socioeconomic terms. That Chicanos continue to live under extremely unfavorable social and economic circumstances is implicit in the definition:

> **The Spanish-speaking minority of the United States of North America is the second largest minority in the United States. They share commonalities and differences as do any other groupings of people.**
>
> **They are primarily Spanish-surnamed, Spanish-speaking, primarily Catholic, they live in a land conquered by the predominate Anglo society and they live in close proximity to their native lands and customs that allow for retention of their culture and life style. The Spanish-speaking people experience poverty and denial of economic opportunity at a level little realized by the average American.**
>
> *Spanish-speaking Americans make up roughly 5 percent of the population,* **making them the second largest minority group—about half the size of the Negro population.**
>
> **In contrast with the widely held view that most Spanish-speaking are migrants or live on farms,** *80 percent reside in urban areas,* **46 cities throughout the country have target populations over 10,000.**

[1] U.S. Department of Labor, Report on the Manpower Needs of Spanish-speaking Americans, prepared by S. Bell, L. Cardona, R. Ontiveros, and M. Ramirez (Washington, D.C.: U.S. Department of Labor, 1970), p. 5–6.

The largest and most impoverished Spanish-speaking groups are Mexican Americans (55 percent) and Puerto Ricans (16 percent); **Cubans, Central and South Americans, and other persons of Spanish origin tend to be better educated and have relatively higher incomes.**

Seventeen percent of Spanish-speaking incomes are below $3,000 poverty line, **compared with 10 percent of all other Americans.**

Unemployment is high: **16.0 percent compared with 10 percent for persons of other origin (in November 1969 when the overall level of economic activity was better).**

The Spanish-speaking are concentrated in lower-paying occupations; **only 25 percent of Spanish-speaking are in white collar jobs—41 percent for the rest of the population.**

Lowest level of educational attainment of any Americans; **8.5 median years of schooling for Spanish-speaking persons 35 years and older, 12.0 years for others; less than 12 percent of Spanish-speaking adults have attended college with the exception of Native-Americans.**

Language barriers are severe **with one adult in three illiterate in English and perhaps one in ten unable to speak the language necessary for economic viability.**

Major obstacles are posed by cultural characteristics and differing value orientation of Spanish-speaking persons due to the lack of understanding of the larger society coupled with a partially self-imposed ethnic isolation of the group itself.

La Raza, pride in a unique ethnic heritage of Spanish-speaking peoples, has yet to be creatively linked **with the economic promise of our society in ways that enrich the cultural heritage of all Americans.**

It was also found that in California 40 percent of those convicted of narcotic offenses were Chicanos, **that alcoholics still constitute a disproportionate number of arrests in barrio areas. The services offered in the area of mental health are still not commensurate with the needs of Chicanos.**

Ernesto Galarza launches the Goleta conference in 1970. In the midst of a police-student riot outside, he brings history, warnings, a definition of mental illness. **(See p. 14 below).**

The medley of definitions alluded to above serves specifically to describe Chicanos in terms of economics, life style, cultural values, and sociopolitical outlook. This characterization has been viewed with suspicion by those who contend that mental health problems among Chicanos stem from their unwillingness to conform to Anglo standards of assimilation.

Mental health problems among Chicanos have either been diagnosed along clinical lines or attributed to structural inadequacies in the social system. Clinical statements include those that profess to show that Chicanos are genetically inferior.[2] In fact, there seems to be a propensity among clinical psychologists to attribute mental unbalance and dysfunction among Chicanos to genetic makeup. Other clinicians hypothesize that Chicanos come from an environment deficient in intellectual stimuli, particularly during formative years.[3] Other theories indicate that socialization patterns among Chicanos are inadequate, compared to those of the Anglo nuclear family,[4] or that Chicanos come from a culture that is hostile to technical progress.[5] Such analyses have definite racist connotations, and they are wholly unacceptable to Chicanos and Third World people.

Mental health problems among Chicanos are more rationally and logically attributable to structural deficiencies in the social system, i.e., lack of access to the opportunity structure. This assumes many forms, such as denial of access to professional accreditation and educational opportunities. Nowhere is denial more obvious than in the educational system. At all levels, schools and colleges operate in a manner that tends overtly or covertly to deny Chicanos sponsorship in everything from student clubs to programs in Chicano studies. Chicanos, moreover, are falling further behind in their understanding of what it takes to survive in a complex capitalistic system. Other frustrating problems that affect the mental well-being of Chicanos include discrimination in hiring practices and debasement of the Chicano culture by the dominant society.

The point to be made here is that the varied assortment of clinical terms used to describe mental health problems among Chicanos, such as "mental unbalance," and "dysfunction," are more realistically manifestations of distrust for a socioeconomic and political system that Chicanos see as grossly unfair. In other words, adequate health programs can be developed only if the complex of factors that exacerbate mental health problems among Chicanos are clearly understood in terms of cause and effect.

The points indicated below are related directly or indirectly to the lack of access to the opportunity structure. As such, they serve to summarize why Chicanos often feel frustrated with life in a predominantly Anglo society that purports to give everyone equal opportunity. Among these may be listed (1) extremely limited potential for economic security, compared to other citizens, (2) general unwillingness of the dominant society to restructure the job market to increase employment opportunities for Chicanos at professional and subprofessional levels (despite federal affirmative-action guidelines), (3) lack of political power, (4) lack of opportunities for creative expression because of economic constraints, (5) lack of respect among white middle-class America for the Chicano people, their customs, beliefs, etc., and (6) an economic stranglehold tantamount to feudalism as a result of Chicanos being forced into barrios following the economic obsolescence of urban society.

These are some of the underlying causes of so-called mental "inadequacies, unbalances, and dysfunctions," among the Chicano people. Lacking full access to the opportunity structure, Chicanos see themselves as pawns in a racist society in which white skin is a prerequisite to social and economic success. We see, moreover, that to provide for the mental health of Chicanos requires that their needs be specifically identified, irrespective of whether those needs are similar or dissimilar to those of other minorities. For example, Chicanos and Mexican-Americans have certain problems in common, although each group may adopt different styles to solve these common problems. Strategies for survival adopted by Chicanos are Chicanismo oriented

---

[2]A. Jensen, *Social Class, Race and Psychological Development* (New York: Holt, Rinehart & Winston, 1968).

[3]R. Hess, *Compensatory Education for Cultural Deprivation* (New York: Holt, Rinehart & Winston, 1965); M. Deutsch, "The Disadvantaged Child and the Learning Process," in *Education in Deprived Areas* (New York: Teachers' College Press, Columbia University, 1963); J. McV. Hunt, "Graduate Training: Some Dissents and Suggestions," *The Clinical Psychologist*, 1969.

[4]D.P. Moynihan, *Maximum Feasible Misunderstanding: Community Action in the War on Poverty* (New York: Free Press, 1969).

[5]O. Lewis, *Five Families* (New York: Basic Books, 1959).

and, hence, are perceived to be entirely appropriate in terms of mental health, particularly since Chicanos persist in their struggle for equality despite tremendous odds. Nowhere is this spirit more aptly expressed than in the slogan adopted by many Chicanos: "Nosotros venceremos." Such a slogan is indeed a tribute to the mental health and perseverance of the Chicano people.

Training Programs Consonant with the Principles of Chicanismo

Given that Chicanismo is a positive social phenomenon, there is need to develop mental health programs that espouse this concept. For example, in terms of Chicanismo, what attitude should Chicanos have regarding alcoholism, drug addiction, violence, religion, male-female relationships, child rearing, machismo, feminismo, self-esteem, etc.? These are questions of vital concern to mental health specialists in the United States, particularly those who work in barrios. Inasmuch as parteras, curanderos, brujas, yerberos, and other lay practitioners have been used in folk medicine since time immemorial, their place in the overall scheme of mental health programs also must be researched and defined.

In keeping with the spirit of self-determination, there also is need to intensify training of Chicano mental health specialists along cultural lines. All training programs should emphasize cultural values rather than excluding or minimizing them. Given the opportunity, Chicanos will again demonstrate their ability to efficiently and judiciously assume responsibility for mental health programs with which they are charged.

We have alluded above to the desirability of utilizing the cultural values of Chicanismo in training Chicanos in the mental health sciences. The Santa Clara Social Action Research Center (SARC) in California has carefully considered this possibility. In this regard, SARC concluded that the most important questions are (1) What is the extent of emotional and mental health problems among Chicanos? and (2) How should future programs be tailored to meet mental health needs of Chicanos? Adequate data to answer the first question must be compiled strictly by Chicanos, to keep Anglos from extrapolating perceptions of mental health that are not applicable to the Chicano community. Simply stated, Chicanos know what mental health is all about in their communities and are no longer willing to let Anglos be the judges. How programs should be tailored depends to a great extent on assessment of bona fide mental health problems in specific communities. Mental health services should be designed to meet real needs in terms of mental dysfunction, unbalance, etc., among Chicanos—not to solve what Anglo practitioners term the "Chicano problem."

An adequate definition of mental health *from a Chicano perspective* is at the crux of the matter. Dr. Ernesto Galarza, in his paper presented at the Goleta Conference sponsored by the Western Interstate Commission for Higher Education, discussed mental health of Chicanos as follows:

. . . But first I want to define what *mental illness* means to a layman. I don't pretend that it has any psychological insight but it is my working rule. First it means the *inability of the individual as he grows older in years to overcome the experiences of early childhood that prevented him from becoming an integrated personality*. We have to reckon with the experiences which prevented us from becoming better-intergrated persons than we are today. Mental illness is the inability to reckon with and overcome the damage that was done when we were young by family life, institutions, and all sorts of agents. Second, it is the *inability of the individual to supply himself with the essentials of biological satisfaction*. I am taking the word "biological" in its broadest meaning: decent housing, healthy sexual relations with a partner, a mature ability to deal with both the young and old. If the adult cannot supply himself with minimum response to meet these biological needs, then he is mentally ill. Finally, mental illness *is the inability of the individual to find in society the reflection of self-esteem which he needs*. With this working definition of mental illness, I find myself about to distinguish among the causes of anxiety and stress of individuals whom I meet in my work.[6]

The following is another excerpt, from a paper read by Dr. Octavio I. Romano-V. at the Goleta Conference:

I am not a specialist in mental health. I think that if I were, I would give a very high priority to launching an intensive investigation into the mental health of the people who have tested Spanish-speaking students in English and then labeled them mentally retarded. Such a distortion of reality is absurd. Somehow, as we go through the figures, we find that in 1966 there were 30,000 Chicano students in mentally retarded classes in California alone. Individuals involved in this absurdity were counselors, psychologists, and school teachers. It is unbelievable that anything like this

[6]Ernesto Galarza, "Institutional Deviancy: The Mexican-American Experience," in *Mexican-American Mental Health Issues: Present Realities and Future Strategies*, ed. by Stanley W. Boucher (Boulder, Colo.: WICHE, 1970), p. 8.

could happen in a technological, urbanized, scientific, industrial society—and yet, it has happened.

What I have to say today really represents a further pursuit of this theme. If I am to pursue the subject of mental health among Chicanos, I cannot help but draw parallels between the peculiar beliefs of the Anglo culture which surrounds them. It seems, for example, absolutely idiotic to have a book like *Mexican-Americans: A Subculture* focus so strongly on witchcraft, and never once refer to Anglo-American witchcraft, which most of us know is a major industry. If I were going to study Chicano witchcraft, I would want to compare it to the Anglo witchcraft. Only in that way would we get some kind of balanced picture. Or suppose I was to focus on such a concept as "fatalism." It seems useless to me to discuss Latino fatalism and ignore fatalism as it exists in the United States as a whole. When the Latino shrugs his shoulders and says, "What the hell!" this is fatalism. When the Anglo does it, then it is alienation. If you read the literature of alienation and then go through the literature of fatalism, you will find that the words describing the conditions are almost identical. Only a different set of semantics is employed. . . . .

What I am saying, of course, is that fatalism, witchcraft, folk medicine, strong family ties, even machismo, are very strong Anglo-American characteristics. But in dealing with the Chicano, these characteristics are isolated and handled as if Chicanos were unique. Being unique, they are different. Being different, they must be deviant. Or, as Celia Heller, the Hunter College sociologist, is so fond of saying, they are "less Americanized." Or as Lyle Saunders likes to say, "unacculturated." Or as Florence Kluckhohn would have us believe, "steeped in a traditional culture of fifteenth-century Spain." The Chicano orders his universe along "affective lines," whereas the Anglo orders his universe along "instrumental lines." Translated into English, this means "We are rational, they are not. They are emotional people." So if I were a specialist in mental health, not only would I study the high school counselors who label Chicanos mentally retarded, but I would also study the mental health of the social scientists who have written about the Chicano.

Perhaps I would select another route. I would go through the categories that one encounters in the field of mental health, such words as deviant, irrational, pathological, dysfunctional, neurotic, and so on. I was talking to Armand Sanchez not long ago, and it dawned on us that these words do not exist in the barrio. How many times have you heard the word deviant or neurotic? This is quite interesting. If such words are not used in the barrio, does that mean that Chicanos behave differently, so that there is no need for these words? It seems to me that there is certain behavior that could be labeled "not acceptable" in the barrio. What are the words used to describe this? And this is crucial—the labels you use to describe human beings are very crucial indeed, because everybody knows that in medicine the label denotes the treatment. So what do you have in the barrio? You have words like *esta loquito; es sonso;* even *menso, esta zafado.* What are the differences between the barrio terms and the technical terms? The technical terms like "dysfunctional," "irrational," "pathological," are separating terms. By a word or label you separate them out. But the counterparts in the barrio are not separating terms; they are descriptive terms through which a whole series of incorporating mechanisms takes place. What I am trying to say is that, in the barrio, you don't have a polarized duality—rational/irrational, functional/dysfunctional. To put it in other terms, what I am saying is that a Western European model is dysfunctional when studying the Chicano, possibly irrational.

I have dwelt to a slight degree on what the Chicano is not. He is certainly not what appears in Celia Heller's book on Mexican-American youth. What I think of when I think of that book is a quote in which she says, "it may be suspected by some that the high degree of delinquency in the Mexican-American community stems from deviance, but this is not the case. It stems rather from over-conformity to the culture." I think in that one quote you find the reason why such books persist in being so popular. What they essentially say, of course, is that the Chicano culture is a major cause of crime among its people. When you wonder why that book is in its fifth printing, it becomes very plain that it is because it tells people what they want to hear. Such books grossly over-rely on such ideas as *el campesino* (the field worker) and the agrarian society. Their authors go into a Chicano area like South Texas, New Mexico, or Arizona and see Chicanos working in the fields—therefore, they must all be agriculture types. This then becomes the basis for constructing the study. In actuality, of course, in the migrations that have taken place from Mexico to the United States, there have been musicians, bartenders, blacksmiths, jewelers, carpenters, Indians, religious people, atheists, masons, counter-revolutionaries, philosophers, and just about every other category of human occupation and existence that you can think of. For many the only work available was in the fields; ergo, they must all be agricultural.[7]

* One of the authors of this paper was recently personally involved in retesting a Chicano prisoner jailed in the Marysville jail on a charge of first-degree murder. He had been tested and declared fit to stand trial by an Anglo psychologist. In retesting the prisoner, who spoke no English, he remarked that the psychologist who had tested him before spoke no Spanish. Our results indicated that the prisoner was not fit to stand trial. He suffered from symptoms of schizophrenia and was clearly losing touch with reality. He was judged not able to stand trial and has been sent to the state hospital in Napa for treatment.

[7]Octavio I. Romano-V., "The Impact of the Mental Health of Anglo Social Institutions upon the Mexican-American," in *Mexican-American Mental Health Issues: Present Realities and Future Strategies*, ed. by Stanley W. Boucher (Boulder, Colo.: WICHE, 1970). p. 41-42.

General Health Status and Care-Seeking Patterns of Migrant Workers

Some of the best research dealing with migrant health studies has been published by Dr. H. Peter Chase, pediatrician at the University of Colorado Medical Center. Chase has noted the following facts about the health characteristics of the itinerant farm-worker family (based on representative samples): (1) an infant mortality rate of 6.3 percent, which is about twice that of the U.S. national average, (2) a life expectancy of approximately 49 years, (3) general lack of prenatal care (less than one-third of the pregnant women receive prenatal care), and (4) serious vitamin A and folic acid deficiencies comparable to conditions found in children from 11 developing nations in Asia, Africa, and Latin America.

The foregoing serves to indicate the plight of migrant workers in terms of malnutrition. Moreover, because of malnutrition, squalid housing, and pesticides poisoning, migrants are strongly predisposed to diseases in general, particularly respiratory and gastrointestinal diseases. The same may be said of other migrant workers, including Puerto Ricans, Blacks, Filipinos, and Native Americans.

In terms of seeking health care, migrant workers display a crisis-oriented pattern, which should be corrected. Limited by economics, and often unaware of the nature and value of preventive medicine, migrant workers for the most part do not enter the health care system except in cases of acute emergency. Preventive medicine is generally foreign to them, much as is holding funds in escrow for projected tax purposes. Moreover, few farm workers, particularly those who follow the migrant stream, purchase health insurance, nor are they eligible for such as seasonal employees. In addition, medical practitioners in rural areas are often reluctant to treat indigent farm workers.

Even more appalling, some physicians, particularly older practitioners, look with disdain or condescension on farm workers as patients because they lack the language skills and cultural knowledge required to communicate with them.

Health Insurance

Farm workers are rarely in a position to afford even low-cost insurance, given that most of their earnings go to provide the basic necessities of life. There is nothing to indicate, however, that migrant farm workers and/or those who have settled out of the migrant stream would not be willing to take advantage of a low-cost system of health care. Like anyone else, they would have to be convinced that the overall benefits of health insurance warrant the cost, particularly since migrant farm workers practice a form of survival economics unlike that of the general population.

Any proposed system of health care would require that migrants have access to counselors trained in health care to help them interpret complex instructions for submitting application forms, filing insurance claims, etc. Even in exceptional cases where migrant workers have participated in health insurance plans, e.g., in certain agricultural processing plants, they have deplored the task of filing claims and applications, and they are convinced that the benefits of health insurance are not commensurate with the cost.

Three specific program goals for mental health are proposed for the migrant and rural poor:

1. **Delivery of health care (physical and mental):** We propose multipurpose health centers, Centros Familiares, in which all necessary services are under one roof. Such centers should be linked with extant medical facilities where possible. Components of social welfare, education, economic, and legal services should be a part of the one-roof concept approach. It is further proposed that a thorough assessment of existing services for migrants and rural poor be made in specific regions, accompanied by qualitiative and quantitative descriptions of specific available services. Such assessments should include modalities of who, how, where, and when migrants and/or rural poor enter health care systems. Factors that prevent migrant workers from entering the health care system tend also to dissuade urban Chicanos from seeking health services. Two facts account for this: First, systems of health care with which Chicanos can identify are virtually nonexistent, and, second, the mobility of migrant workers poses an extremely difficult problem in terms of logistics. The question becomes how best to offer health care services to a large number of Chicanos, many of whom are constantly on the move. Extant programs of health care should be monitored and a feedback system used as a basis

for modification and necessary change. Such an approach would insure that mechanisms for changes come about as a result of input from recipients of health care. Consumer representation must be assured if substantive changes are to become a reality.

2. **Health education**: There is a need to disseminate health training information in Spanish and/or English to migrant workers, rural residents, and Chicanos living in urban areas. Responsibility for synthesis of health information and dissemination of printed material should be assumed by professional and paraprofessional workers in the barrios, colegios, and Centros Familiares. It is important that in all cases information be relevant to the target population.

Equally important is the establishment of a health linkage system, i.e., a system of constant intercommunication between Centros Familiares, to create solidarity of purpose. Such a system would not only promote interchange of ideas, but would encourage development in due course of a sound theoretical base and strengthen capacity for innovative health delivery systems that Chicanos so urgently need.

3. **Career development**: There is definite need to attract more Chicanos into the mental health field at all levels of specialization. Provision must also be made for the identification and certification of curanderos, sobadores, parteras, yerberos, etc., to assist in the work of the Centros Familiares. The various techniques and general expertise of these practitioners should be made known to all concerned, so that adequate referrals can be made to fit the needs of individual patients. The practitioners referred to above should be an integral part of the staff in the Centros Familiares. Moreover, such individuals, as practitioners and members of the barrios and communities, would serve admirably as role models for students and others who wish to enter the mental health field.

Through the one-roof concept of health care, staff members of the Centros Familiares, including the curanderos, sobadores, etc., would participate in an outreach program of health care services. Folk practitioners and other paraprofessionals would be encouraged to move up the professional ladder under this system. The means to do so would be made available by matriculation at Chicano-affiliated colleges and universities, particularly those with strong Chicano studies programs that offer courses in folk medicine and related fields. Such a plan would not only help develop a relevant system of health care but would also provide a strong framework for career development.

Mariano Aguilar describes a new kind of Chicano organization—the paraprofessionals organize and run it, hiring experts when they need them.

At Goleta: Juan Acevedo on the left, Armando Morales and his wife, with Alicia Noriega on the right. Delegates still wore name tags at the early conferences.

Paul Sanchez: there should be a followup conference—we should study how the "system" works. . .

CHAPTER 4
ADDICTIONS: HARD DRUGS

An Overview of Drug Abuse

Unlike the causes of addiction among affluent Americans of white middle class society, addiction to alcohol and/or drugs in the barrio is primarily the result of interrelated factors in which *poverty* is the common denominator.

While there can be no doubt that poverty has a universal negative impact on people regardless of ethnicity, the etiology of addiction among Chicanos and whites, generally speaking, seems to differ. Alluding to these differences, Crowther stated,

> **One might speculate . . . that Chicano . . . users began their narcotic use to become addicted rather than to experiment "for kicks." It is possible that the escape properties of the drugs are one of the major reasons for use among . . . our . . . subculture. The life of the . . . Chicano . . . in the Southwest is a hard one in that he occupies a low status position. It is possible that the lower class . . . Chicano . . . sees heroin as a means of escaping responsibility and the difficult life cycle that envelopes him.[1]**

The following excerpt serves to illustrate the almost insurmountable difficulties ex-addicts face in attempting to readjust to civilian life following release from prison:

> **As a group, Mexican Americans have been unable to move into the mainstream of American economic life. Taking the Southwest as a whole, their unemployment rate is about double that of Anglos. . . .**
>
> **More important, perhaps, than the gross unemployment picture are other characteristic patterns:**
>
> **—There is widespread underemployment. Many Mexican Americans do not have full-time, year-round jobs.**
>
> **—Mexican Americans are heavily concentrated in the lowest paying jobs.**
>
> **—There are certain important kinds of business and industry in which Mexican Americans appear not to have made significant inroads at any level . . . . in . . . some of the most important growth industries and companies—aircraft, telephone, space, and electronic and allied industries—Mexican American employees total 5 percent or less.[2]**

Even after facing the reality that drugs cannot provide continued escape from poverty, racial discrimination, and an uncertain future, the addict faces tremendous obstacles in his attempt to rehabilitate: the "ex-con" label is still with him, job opportunities are apt to be minimal because of his low level of education and training, and he is likely to be shunned despite having paid his "debt" to society. In other words, the ex-addict faces a form of double jeopardy—being Mexican-American and being an ex-addict.

This section of the plan describes the socioeconomic environment in which Chicanos become addicts and includes recommendations for rehabilitation and prevention of addiction among the young.

California reflects one of the most serious problems of drug abuse among Chicanos in the country. The largest concerntration of Chicanos in California is in East Los Angeles, which lies outside the city limits in Los Angeles County. The area is economically depressed and has many of the social and economic problems that characterize similar urban areas, including inadequate mental health services. The area has only two mental health facilities: (1) the Los Angeles County General Hospital Psychiatric Ward, with a 25-bed capacity, and (2) the East Los Angeles Mental Health Clinic, for limited outpatient services. Both inpatient and outpatient mental health services are greatly overloaded and cannot meet existing demands in the area.

The following figures serve to reflect the index of drug abuse in the East Los Angeles area: Of the 3,000 addicts currently under the supervision of the California Rehabilitation Center, 1,200 are

[1]Betty Crowther, "Patterns of Drug Use among Mexican Americans," *The International Journal of the Addictions*, Vol. 7, No. 4, p. 646.

[2]Helen Rowan, "The Mexican American," a paper prepared for the U.S. Commission on Civil Rights, 1968, p. 38.

Chicanos; of these, 720 live in Boyle Heights. According to statistics of the Narcotics Prevention Project, there are approximately 16,000 Chicano addicts living in areas such as Lincoln Heights, Montebello, Pico Rivera, El Monte, and San Gabriel.

According to Little,

> **One index of the drug abuse rate in this area can be seen in the number of juvenile and adult narcotic and drug arrests. A second index consists of the percentage of requests for detoxification services . . . at Metropolitan State Hospital, Rancho Los Amigos Hospital, Palmdale General Hospital, Los Angeles County General Hospital, and Rosemead Lodge. . . . A third index can be found in the percentage of drug offenders from the East Los Angeles area who are currently in the three California Department of Corrections institutions. . . .**
>
> **The rate of juvenile and adult arrests in the area has more than doubled since 1968; in 1968 the combined figures were 677 while in 1969 the combined juvenile and adult arrests totaled 1,208.**[3]

Both the seriousness and pervasiveness of the drug problem in East Los Angeles are implicit in an Arthur Little report on the area. The strong social and cultural ties of the community to which the Little report alludes, however, should greatly favor educational programs implemented to curb drug abuse in the area and use of mental health services proposed in this plan.

Drug Use Patterns

Marijuana. Although millions of white people are purported to smoke marijuana or hashish daily in the United States, its use is not generally connected with crime or antisocial behavior—unless the users are Chicanos, Blacks, or other minorities. Recent research with Rhesus monkeys indicates that brain cells are permanently or semipermanently impaired by heavy and sustained use of the drug, although allegations that users generally develop a propensity for psychopathic behavior have yet to be substantiated by adequate research. Like other drugs, including tobacco and alcohol, marijuana no doubt helps young and old escape the realities of poverty, including an uncertain future, unemployment, low-paying menial jobs, substandard housing, and broken homes.

Amphetamines, barbiturates. Like marijuana, amphetamines and barbiturates are indiscriminatly used by people of all ages and social classes. Use of "downers" or sleeping pills (barbiturates) and "uppers" or pep pills (amphetamines) pose the most serious drug abuse problem among young adults of junior high and high school age. Amphetamines affect the central nervous system, causing users to become highly excitable. It is not uncommon for students who are strung out on pep pills to be thrown out of class for unruly behavior.

Excessive ingestion of barbiturates causes physiologic, pathologic, and/or psychologic changes by affecting the higher centers of the brain. Currently, about 20 deaths a month due to overdoses of barbiturates are reported at the Los Angeles County General Hospital.[4]

The need of educational programs to alert young and old to the dangers of indiscriminant use of amphetamines and barbiturates is obvious, and such programs are long overdue. They are recommended in the overall plan to curb drug abuse among Chicanos, particularly the young.

Paint and glue sniffing. Although precise figures are not available, it has been estimated that 5 percent of grade school and junior high school children have experimented with paint and acetate glue sniffing. For the very young, inhalation of the volatile emanations from paints, aerosols, and acetate glues is extremely hazardous and can result in lung poisoning, nephritis, cardiac arrhythmia, renal shutdown, etc. To expect youngsters to intuitively understand the hazards of paint and glue sniffing is unrealistic, and, hence, children must be made to realize that such practices can result in serious health defects or even death.

Heroin. Addiction to heroin has been the curse of Chicano males since World War II. Throughout the Southwest, the increase in addiction of Chicanos to heroin is reflected in the increased admission rate of Chicano addicts to the Lexington and Fort Worth hospitals. In 1961, there were 102 Chicanos in these hospitals for the addicted. By 1967, this number had increased to approximately 400.

---

[3] Arthur D. Little, Incorporated, *Rehabilitating the Narcotic Addict, An Evolution of O.E.O. Projects*, Vol. II (June 30, 1971), p. 4.

[4] Juan D. Acevedo, Executive Director Narcotics Prevention Project, East Los Angeles (personal communication, 1973).

To bring into focus the scope and seriousness of heroin addiction among Chicanos and the interrelated factors that lead to addiction, the Lexington hospital for addicts offerred the following data:

1. The incidence of Mexican-American addicts admitted between 1961 and 1967 doubled, even though admissions in general dropped 21 percent.

2. During the same period, Mexican-American female representation dropped; in 1967 there were less than half as many females admitted as in 1961.

3. In 1961, California had the majority of placements; currently, the majority of those admitted are from Texas.

4. Of the various ethnic groups, the highest incidence of school drop-outs occurred among Mexican-Americans.

5. Most Mexican-American addicts were legally employed during addiction but supplemented their income from illegal sources.

6. Most Mexican-Americans used marijuana before becoming addicted to heroin.

7. Most Mexican-American addicts with a long history of arrests began using heroin at age 14.

Treatment Modalities.

In recent years, rehabilitation programs for Chicano addicts have been predicated more and more on recommendations made by former addicts, many of whom continue to play important roles in rehabilitation programs in the barrios of the United States.

In fact, in a study conducted by Anthony Lopez in 1973,[5] 18 Chicano ex-addicts from East Los Angeles indicated that former drug addicts like themselves were more helpful during their period of rehabilitation than psychologists and psychiatrists who, incidentally, were rated extremely low by all respondents in the study. In that most of the published literature on drugs is written by psychologists and psychiatrists, the low rating accorded them by all respondents seems incongruous.

The same group of ex-addicts differed in their opinions regarding treatment modalities. A few believed punitive models to be best; the majority, however, considered religious models to be superior and most effective. These differences of opinion are understandable insofar as treatment modalities are concerned, given the differences in psychological makeup and other variables in personality makeup. There was general consensus, however, that programs for resocialization must be community based and must provide a wide range of services under one roof—detoxification facilities, employment counseling, maintaining adequate relations with parole officers, financial assistance, and personal and family counseling.

Education

Strictly speaking, the quality of education sooner or later affects the community, in either a positive or negative manner. There is no need here to dwell on the positive impact that quality education has on any community, except to add that an educational system that is poor is bound to have a negative impact on any community, regardless of ethnic makeup. In other words, as long as citizens fail (because of an inadequate educational system) to learn how to make the socioeconomic system as well as the political system serve their needs, they are bound to feel disenfranchised and frustrated. Given that Chicanos begin to feel disillusioned early in life, it is not surprising that they tend to turn to drugs sooner or later. Even the naive and uninitiated appreciate that the disenfranchised are more apt to turn to drugs (or alcohol) than those who feel they "belong"—regardless of ethnicity.

There is abundant evidence of "public concern for the special educational problems of the Chicanos in the records of teachers' conferences and workshops beginning in the 1930's."[6] Unfortunately, little research has been conducted to explain the relatively low success Chicanos have had in dealing with the Anglo system of education. In "explaining" the low success rate, researchers have too often simply confirmed that Chicanos tend to

[5]Anthony Lopez, *The Former Chicano Drug Addict: A Study of Three Different Drug Abuse Treatment Modalities* (Master's thesis, University of Southern California, Los Angeles, Calif., June 1973).

[6]Thomas P. Carter, *Mexican Americans in School: A History of Educational Neglect* (New York: College Entrance Examination Board, 1970).

. . . (1) do poorly in school, (2) drop out early, (3) speak Spanish, and (4) be poor. The relationships between these four factors are usually seen as causal . . . thus, . . . Chicanos do poorly in school because they are poor, speak Spanish, and are culturally Mexican.[7]

In explaining Chicanos' low rate of academic success, researchers tend to give inadequate attention to the socioeconomic system in which Chicanos must compete, the racist attitudes that teachers and/or administrators often harbor toward Chicano students, and the inadequacy of the Anglo educational programs vis-à-vis the Chicano culture. All of these variables make questionable the many cause-and-effect theories "explaining" the high drop-out rate of Chicano students.

In study of teacher expectations for the disadvantaged, Rosenthal and Jacobson

. . . explored the effect of teacher expectations with experiments in which teachers were led to believe at the beginning of a school year that certain of their pupils could be expected to show considerable academic improvement during the year. The teachers thought the predictions were based on tests that had been administered to the student body toward the end of the preceding school year. In actuality the children designated as potential "spurters" had been chosen at random and not on the basis of testing. Nonetheless, intelligence tests given after the experiment had been in progress for several months indicated that on the whole the randomly chosen children had improved more than the rest.[8]

Results of this study suggest that there is a tendency for teachers to see that students live up to expectations. The fact that students identified as "spurters" were merely chosen at random from the sample at large and were not, in fact, shown to be "spurters" by previous testing, as teachers in the study were led to believe, indicates how easily bias can influence professional judgement. Of great importance to Chicanos is the fact that the study also tends to support charges by Chicano educators that biased teachers, who more often than not are Anglos, have come to expect Chicano students to do poorly in school or fail, mostly because they are "supposed to," or because they are "culturally disadvantaged."

In decrying the quality of education for Chicano students in the East Los Angeles area Guzman[9] noted that for Mexican-Americans, surviving the secondary-school educational system is a considerable accomplishment, and he suggests that one of the many things that drives Mexican-Americans from the schools is a custodial manner that emphasizes attendance and discipline at the expense of learning. Guzman adds that the poor quality of schools in East Los Angeles is an open scandal, even among those who teach in and administer them.

The many inadequacies of the educational system, including the naieve biases of Anglo teachers and the pervasive discrimination that Chicanos encounter daily, all tend to exacerbate the many problems that go hand in hand with poverty. Considering the environment in which Chicanos live, it is small wonder that some see drugs as an escape route. Moreover, Chicanos, unlike most Anglos, see themselves locked into an environment over which they have little control.

In a 1966 study conducted by Coleman and others and summarized by Carter,[10] Anglo and Chicano students in the 12th grade were asked three questions to test self-concept and the degree of control they perceived themselves to have over their environment: (1) Good luck is more important than hard work for success. (2) Every time I try to get ahead, something or somebody stops me. (3) People like me don't have much of a chance to be successful in life.

In further summarizing the work of Coleman and others, Carter indicated that in response to all three items, a slightly larger percentage of Mexican-Americans do perceive their environment as less controllable than do their Anglo counterparts. As the researchers point out, high percentages of agreement on these items in the Mexican-American group may reflect their correct interpretation of reality.

Without doubt, the racist educational systems in many barrios of the United States are failing to meet the needs of the Chicano community. In the process, many emotional problems that beset Chicanos by virtue of being poor are being compounded.

---

[7]Ibid., p. 12.

[8]Robert Rosenthal and Lenore F. Jacobson, "Teacher Expectations for the Disadvantaged," *American Magazine*, April, 1968, p. 19.

[9]Ralph Guzman, "The gentle revolutionaries: Brown Power," *Los Angeles Times*, West Magazine, January 26, 1969, p. 11.

[10]Carter, op. cit.

Systems— how the federal government works. Arturo Raya, then a special assistant for health. Behind him Sam Silverstein and Jeannette Chamberlain of the National Institute of Mental Health.

The statistics noted above published by the Lexington hospital for the addicted show that of the various ethnic groups interned, the highest incidence of drop outs occurred among Chicanos. This is what is happening to Chicanos in many public schools. Unless relevant bilingual systems of education are made available, the Chicano self-image will go unchanged, the mental health of Chicano youth will continue to suffer, and the drug scene will also go unchanged or become worse.

General Recommendations

Certification of Chicano paraprofessionals. Ideally, drug abuse programs should develop common criteria for certification of paraprofessionals. Certification would require training or experience, such as language skills and previous experience as medical technicians in the military, that would help meet the needs of the community. Certified paraprofessionals would include qualified ex-addicts in the community who sincerely wish to eliminate the drug problem in the barrios.

One of the most important programs currently underway to certify paraprofessionals is the University of Southern California Paraprofessional Training Program. The purpose of the program is to apply the expertise of both former addicts indigenous to the specific target areas and non-addicts in drug control programs. Three agencies are pooling their resources in the certification program; they are the Division of Social Community Psychiatry of the University of Southern California, which provides education and experience relevant to psychological and interpersonal problems; the Narcotics Prevention Project, which provides instruction and experience in rehabilitation and community matters: and the Rancho Los Amigos Hospital, which deals with overdosing and detoxification.

The coordinated effort of the three agencies makes it possible to train individuals in each facility for six months. Individuals who complete the training period are subsequently employed by directors of drug abuse programs in the community. Successful trainees, moreover, receive university credit applicable to any liberal arts undergraduate program in the university college of the University of Southern California. In addition, civil service officials of Los Angeles County are being urged to solicit from graduates applications for employment as community

workers, psychiatric orderlies, social technicians, hospital workers, etc.

Educational programs in the public schools. School programs to make children aware of the dangers of addiction are sorely needed. Certainly, they are needed as much as programs aimed at curbing venereal disease. Programs to curb drug abuse should have four components:

1. Information

It is important that parents, teachers, guardians, as well as students, be made to appreciate the hazard that addiction to heroin or indiscriminate use of amphetamines and barbiturates pose to mental and physical health. Seminars, films and lectures on heroinism and drug abuse, however, must be adequate in terms of the target audience. Always, addiction and drug abuse must be shown to conflict with the concept of self-preservation and good health from both a physical and mental standpoint.

2. Counseling

Students, parents, and faculty should be counseled in groups or individually to improve rapport between them in matters which involve drug-abuse problems. Counseling should be offered and/or coordinated by directors and staff of local drug-abuse programs. Since individuals often vary in terms of psychological conflict, the widest possible range of counseling services should be made available, including counseling with peer groups, school teachers, former addicts, psychiatrists, psychologists, priests, nuns, etc.

3. Treatment

There must be medical facilities available for immediate use for either emergency first-aid or long-term treatment for amphetamine-barbiturate poisoning, or any other drugs commonly used by students, including marijuana, aerosol paints, and acetate glues. Medical facilities must be available without cost at any time of the day or night.

4. Alternatives

The cultural wealth of Chicanos offers much in the way of prevention and alternatives to drug abuse, particularly for children in their formative years. Important among these are the arts, e.g., Mexican music which almost invariably instills a fierce sense of cultural pride in the listener. Music clubs, including young mariachi groups, chorus ensembles—all community-based, would help provide wholesome diversion for youngsters of all school ages. Such activities, moreover, also would help improve the Chicano's self-image. Theater groups, clubs organized to teach dances indigenous to Mexico would be equally helpful. We see these alternatives to drug use as a means of preventing addiction and promoting mental health at the same time. Such programs could function under auspices of community organizations, or as part of the regular school curriculum. Such diversionary efforts would ward off or reduce chances of turning to drugs.[11]

[11]Juan D. Acevedo (personal Communication, June 1973).

Below is a summary of specific recommendations for solving and/or preventing addiction.

1. Provide therapeutic programs that relate to contemporary needs of Chicanos, and remove those that the community deems detrimental.

2. Provide for the establishment of an institute for study of heroin addiction and drug abuse vis-à-vis the Chicano community, including recidivism statistics.

3. Provide alternatives to addiction through programs of positive social action based on the Chicano culture.

4. Provide for the reassessment of the use of methadone and other antagonists and blocking agents in the Chicano community.

5. Establish a system of hearings and/or reviews of court cases involving addiction within the community.

6. Determine how prison reform currently relates to Chicano prisoners, parolees, and probationers.

7. Develop and amass in the libraries of the community or with directors of drug abuse programs relevant literature, films, audiovisual tapes, and other educational materials on addiction for community use and distribution.

8. Provide for certification of paraprofessionals for work in drug abuse programs; that certification should require (a) field work in the community, (b) middle-management supervisory training, and (c) top-level administrative training.

Certification is intended to show proof that paraprofessional trainees are qualified to work in any of the drug abuse programs in the country. It is recommended that training programs be structured to meet varying needs and that some consist of one or two months of intensive training in administrative skills; on-the-job training should be for six months. It is further recommended that certain programs for paraprofessional certification be sponsored by universities and that such training should fulfill partial requirements toward bachelor's and/or master's degrees in appropriate fields.

Finally, it is recommended that all training programs be accredited by the National Institute of Drug Abuse through a central training program funded by NIDA.

CHAPTER 5
ADDICTIONS: Alcoholism

Alcoholism is one of the leading public health problems in the nation today, and yearly the number of known alcoholics is constantly growing. Alcoholism causes a wide array of social problems along with the psychological and physical deterioration of the individual.

Some of the problems include family discord, poverty, violence, the abuse and neglect of children, suicide, poor work records, unemployability, industrial inefficiency, high rates of other illnesses and social pathology, and special problems associated with alcohol use by young people. These problems affect all segments of society, irrespective of economic, racial, ethnic, occupational or other major characteristics. They are of concern to government, churches, communities, and families. They involve economic, medical, and ethnic questions. They represent an enormous drain on the national economy in manpower lost and societal dependents created. They detract from the nation's vitality for defense. They pose a threat to the health and well being of all citizens, whether directly, indirectly, or remotely affected. Finally, they pose a challenge of enormous proportions to these concerned with devising methods of prevention and control.[1]

Of two million arrests made in 1965 in the United States, one of every three was for the offense of public drunkenness.[2] In 1964 in Los Angeles, about one-fifth of all persons arrested for drunkenness accounted for two-thirds of the total number of arrests for that offense. Some of the repeaters were arrested as many as eighteen times in that year.[3]

According to Morales,[4] arrests for drunkenness and drunk driving account for a little more than 50 percent of all offenses in the Chicano barrio of East Los Angeles, a much higher ratio than in other similar communities in the Los Angeles area. Table I from the Morales study clearly demonstrates the differences between the Chicano barrio of East Los Angeles and the West Los Angeles Valley community. If arrest rates for drunk driving can be used as a measure of excessive drinking, then East Los Angeles can certainly be rated very high. Morales concluded that there are more police working in the East Los Angeles barrio than in any other comparable communities in the Los Angeles area and that arrests for drunkenness and drunk driving increase as the number of police per square mile increases.

Although the incidence of alcoholism is extremely high in most Chicano barrios, little has been written about the causes of alcoholism or the treatment modalities that are available for most Chicanos.

What makes Chicanos turn to alcohol? Is alcoholism a convenient mechanism for self-destruction, as has been claimed for Anglo alcoholics? Is the treatment available to the Chicano, other than jail, relevant to his culture and his background? What resources are available in a typical Chicano barrio for the alcoholic, and who are the providers? What are the rates of recidivism, and what is being done to lower them among Chicano alcoholics? Are the known characteristics of alcoholics, such as rejection, denial, identification, introjection, projection, rationalization, depression, game playing, and acting out, the same for Chicano alcoholics as for other alcoholics? What planning is being done for Chicano alcoholics, and who is doing the planning? Are any recovered Chicano alcoholics involved in the planning process? Are alcoholism agencies now being funded in the barrio that know little about alcoholism and care even less about the alcoholics?

These are but a few of the important questions that should be examined carefully in order to develop services that are relevant to the Chicano

---

[1]National Advisory Committee on Alcoholism, *Interim Report to the Secretary of the Department of Health Education and Welfare* (1968), p. 2.

[2]1965, FBI Uniform Crime Reports 117, Table 25.

[3]Statistics gathered by the Los Angeles Police Department during 1964.

[4]Armando Morales, *Ando Sangrando, A Study of Mexican-American Police Conflict* (Perspectiva Publications, La Puente, California, 1972), p. 38.

TABLE I

DRUNK AND DRUNK DRIVING ARRESTS PER AREA AND POPULATION

1968	LAPD Hollenbeck Area & East Los Angeles Sheriff's Station*	LAPD West Valley Area†
Total population	259,275	260,832
Square miles	26.44	54.81
Ethnicity	50–60% White, Spanish-surname	95% White, Non-Spanish-surname
Median family income	$5680	$8440
Number of Alcoholics per 100,000 pop	8,143	8,143
Drunk & drunk driving arrest	per month: 800	125
	per year: 9,676	1,552
	per sq. mi.: 372	28.5
Police agencies	CHP, LAPD, Sheriff	LAPD‡
Total no. of officers	375	151
Number of officers per square mile	13.5	3.5
Major crime per ratio of population	4.9%	4.8%

*"Total Population" and "Square Miles" includes Bell Gardens, 29,491 people, 2.40 square miles; and City of Commerce, 10,763 people, 6.56 square miles. Bell Gardens and Commerce accounted for 1,168 of the drunk and drunk driving arrests.

†As defined by LAPD.

‡CHP statistics in the West Valley area were not available but even when CHP arrests are subtracted from the East Los Angeles area (approximately 3,000 arrests), there still is a significantly higher ratio of arrests for those offenses in the ELA area as compared to the West Valley area. The LAPD made 2,954 ELA arrests and the Sheriff's office produced 3,722 ELA arrests.

LAPD—Los Angeles Police Department (city)

CHP—California Highway Patrol (state)

Sheriff—Los Angeles County Sheriff's office (county)

The ethnicity and income factors appear in Mental Health Catchment Areas of Los Angeles County, Population and Health Care Resources, UCLA School of Public Health, Division of Behavioral Sciences, April, 1968.

alcoholic. If this is not done, the "revolving-door" cycle prevalent in many treatment facilities will continue to exist.

Many Chicano alcoholics come from a barrio that is poverty stricken. According to Lee,[5] "poverty is not just a matter of having little or no money, rather it means hunger and malnutrition as well, low education levels, poor housing, poor health, broken homes and patterns of behavior that tend to perpetuate the cycle," a pattern that has been described by Oscar Lewis as the "culture of poverty." In the barrios this is known as "pobreza."

As may be noted from the variables in Table II (at the end of this chapter), which were used by the Los Angeles County Department of Mental Health in their Mental Health Index of 1972, the barrio of East Los Angeles is poverty stricken. Yet, according to Mendez,[6] the police and the state prison system constitute the principle "mental health" and rehabilitation service for the alcoholics and drug users of East Los Angeles.

The East Los Angeles area had until very recently no resources for the alcoholic leaving the hospital after detoxification. Because of language, cultural differences, and lack of information, halfway houses had not been developed in this barrio as they had been in other communities. Today there is one halfway house in East Los Angeles.

Alcoholism in any Chicano barrio is a symptom of the intensive problems related to living in a low socioeconomic community. A poor economic base and little political organization have made it difficult to create programs that meet the needs of the alcoholic and his family. The barrio residents have perceived themselves as a disenfranchized and powerless group in a nation of abundance. The problems faced in a Chicano barrio are very complex and interwoven. Because of the many socioeconomic problems that exist, it has been extremely difficult for even the non-alcoholic barrio residents to maintain good mental health and even more difficult for the alcoholic and his family to do so. These

Arturo Raya uses diagrams and boxes on blackboards. Navigation is possible. . .

[5]Philip R. Lee, M.D., "The problems of the minorities rest not with them but with the white majority," *California's Health*, May 1969.

[6]Margarita Mendez, M.S.W., ELA Mental Health Services interview.

notions are, of course, not newly discovered. The early pioneers in public health, more than a century ago, recognized the relationship of poverty to health. In 1909, Dr. Henry B. Favill

challenged his Rush Alumni colleagues: It is idle to discuss mental or moral or physical health in the terms of a slum. It is wasteful to expend unlimited money on hospitals and other corrective institutions, while at the same time we broaden and deepen the social morass which feeds them.[7]

The life style of the Chicano barrio should be a prime consideration in health delivery care, yet the planners and providers of services have not given it serious consideration. Thus far, the traditional mental health and health agencies in the Chicano barrios have generally tended to ignore the problem of alcoholism, or they have developed a limited program based on the Anglo middle-class model. According to Fishman and McCormack,[8] this model of community mental health does not work in a ghetto and it also fails in the barrio. The model for community mental health centers, evolved in recent years, is essentially a modification of the usual institutional model of service and is built around outpatient and emergency services attached to some modified form of extended hospital care. "Offices and hospital walls, like ghetto boundaries have two sides. They keep people in; they keep people out; and they obstruct vision."[9] It is extremely difficult for professionals in a mental health setting to treat a client and effect some behavior modification without fully understanding the life style of the person they are treating.

The irrelevancy of traditional mental health services, according to Torrey,[10] was ingrained in the very concept of the community mental health centers. In his words, "The architects of the Mental Health Act unconsciously and ethnocentrically perpetuated the dominant-class, dominant-culture, dominant-caste model of mental health services as the model." He further stated that the control of and money for mental health services should be firmly in the hands of a board from the Mexican-American community. In addition, the services should be delivered by capable persons, not just by someone with a "certain number of degrees." Torrey summed up by saying, "The services will be used only when they are relevant, and they will be relevant only when they are set up by Mexican-Americans themselves."

In short, what is needed today is a different model of mental health services in the Chicano barrio, a model that is germane to the barrio and addresses the serious problems of addictions along with other mental health problems.

The development of any social or health service should always begin with the assessment of the total needs of the individual and/or the community. The mental health needs of a person or a community do not exist in a vacuum; rather, they relate not only to the total environment but also to the needs of other individuals and to the network of interrelationships that give life and a specific, unique character to a community.

Comprehensive addiction treatment plans must be included in this model in order to break the present revolving-door treatment of the alcoholic. Emphasis must also be focused on coordination, collaboration, and development with other pertinent groups and agencies in and out of the barrio.

The concept of relative deprivation as explained by Dobriner[11] might be one of the major causes for change in the mental health system: "A population feels relatively deprived and they compare their own life fate and opportunities with whites and feel outraged." In the past, few Chicanos left the barrio and were aware of different ways of life, and few felt relatively deprived. By now, many Chicanos have left the barrio and have become aware of a different mode of living. Chicanos today are unwilling to accommodate the traditional system; instead, they are working to change the system to meet the existing needs in the barrios. Although their number may not be great, they have begun to exert pressure in many different ways to bring about the needed change.

---

[7]Lee, op. cit., p. 5.

[8]Jacob R. Fishman, M.D., and John McCormack, M.D., *Mental Health Without Walls: Community Mental Health in the Ghetto.*

[9]Ibid.

[10]Fuller E. Torrey, M.D., "The Irrelevancy of Traditional Mental Health Services for Urban Mexican Americans." Paper presented at the American Orthopsychiatry Association, San Francisco, California, March, 1970.

[11]William M. Dobriner, *Social Structures and Systems* (Pacific Palisades, California: Goodyear Publishing Company, 19690, p. 159.

Graves[12] noted that for Chicanos, acculturation is consistently associated with higher rates of drinking and deviant behavior. The unacculturated Chicanos Graves studied did not display any deviant behavior. The explanations offered are (1) The acculturated members have limited economic access to the rewards of American society, and thus they maintain stronger feelings of relative deprivation, significantly greater alienation, and significantly more psychological problem-solving reasons for drinking; (2) the unacculturated members display strong social and psychological controls (from family and church) that are internalized; and (3) the influence of family and church begins to break down as the acculturated group moves toward the more secular American norm.

In another study of agringados (acculturated Mexican-Americans) Madsen[13] pointed out that the cultural setting of the agringado involves value conflicts resulting in loss of identity and community—a loss that seems to be conducive to alcoholism. This is particularly true when the individual has been exposed to the tradition that alcohol may function as an escape mechanism. Madsen also pointed out that any therapy that deals with alcoholics who have value conflicts with cross-cultured references must take into account the sociocultural variables involved.

Pearson's[14] analysis of the Chicanos, who make up 20 percent of the clients seen at the Los Angeles Alcoholic Rehabilitation Clinic, also noted that all the nonassimulated Chicanos in his study demonstrated improvement, whereas only 30 percent of the assimulated group improved. Pearson speculated that some of the reasons for the success of the nonassimulated group could be (1) acceptance and cooperation of the entire family, (2) respect and cooperation with authoritative figures such as the doctors, nurses and social workers, (3) treatment by a Spanish-speaking staff, and (4) acceptance of alcoholism as an illness.

Considering the implications of these findings should lead to more careful examination of the Chicano alcoholic and also a careful review of the acculturation process in the Chicano barrio.

The recovered alcoholics and their families are the group with a strong interest in alcoholism and, yet, in the Chicano barrio they have not been involved in treatment of alcoholism. It is time to assess the problem of alcoholism in the barrio and to do something positive about it. Alcoholics can be helped in various ways; there is no one answer to the problem. Some might be helped by Alcoholics Anonymous, others by medication or community involvement, and still others might respond to a church program or Chicanismo. Many avenues of help for the alcoholic in the barrio must be developed to assist him to get back into the mainstream of life. It is important that in whatever program is developed, mental health professionals assume an active role and that together with community residents they plan and implement a beneficial program for Chicano alcoholics.

Eloy Apodaca, listening.

[12]Theodore D. Graves, "Acculturation, access and alcohol in a tri-ethnic community," *American Anthropologist* 69 (3-4), p. 306-321, 1967.

[13]William Madsen, "The Alcoholic Agringado," *American Anthropologist* 66 (2), p. 355-361, 1964.

[14]A. W. Pearson, "El Tratamiento de Alcoholismo de Mexicanos que viven en los Estados Unidos (The Treatment of Alcoholism in Mexicans in the United States)," *Revista Mexicana de Psicologia*, 1 (4), p. 358-362, 1964.

TABLE II

MENTAL HEALTH INDEX[15]
1972

Population (1970 census)—361,755
18 years old and under—135,966
65 years old and over—31,889

OVERCROWDEDNESS (1970 census)
Number of persons per room

	Rate per 10,000 units	*Rank*	*Total population*
ELA	2,087.2	2	156,260
NE	2,069.8	3	205,495
Total			361,755

	Population per square mile	*Rank in density in county*
ELA	6,884	11
ELA region	8,166	3
NE	9,514	6

PERSONS LIVING ALONE (1970 census)

	Number	*Rate*	*Rank*
ELA	7,728	1,692	18
NE	13,680	2,191.6	11

POVERTY (1970 census)
Poverty income is defined as that below $3,745 for a family of four for 1969.

	Total number of families	*Number of families below poverty level*	*Percentage*
ELA	37,412	4,857	13
NE	47,045	7,612	16.2
ELA region	84,457	12,459	14.8

ALCOHOLISM (1965)
Rate based on number of known deaths due to cirrhosis, using the Jellineck formula.

	Rate	*Rank*
ELA	10,847	10
NE	8,984	3

[15]Mental Health Index, 1972. Los Angeles County Department of Mental Health Los Angeles, California.

DRUG USE (1970)

Rate based on death certificates with mention of narcotics.

	Rate	*Rank*
ELA	62.5	5
NE	56.9	6
ELA region	59.4	4

Adult and juvenile probation drug cases.

	Number	*Rate*	*Rank*
ELA	328	209.9	3
NE	363	176.6	6
ELA region	691	191	

DELINQUENCY (1970)

Based on juvenile probation cases.

	Number	*Rate*	*Rank*
ELA	323	200.6	12
NE	543	266.2	6
ELA region	863	239.4	3

ADULT CRIME (1969)

Based on adult probation cases.

	Number	*Rate*	*Rank*
ELA	1,200	768	3
NE	1,073	522.2	7
ELA region	2,273	628.3	

STATE HOSPITAL ADMISSIONS

1970 Fiscal year

	Number	*Percentage*
ELA	154	1.42
NE	167	1.54
ELA region	321	2.96

1971 Fiscal year

ELA	727	5.16
NE	730	5.18
ELA region	1,457	10.34

L.A. COUNTY INPATIENT ADMISSIONS

1970 Fiscal year

	Number	*Rate*	*Rank*
ELA	225	144.3	7
NE	423	206.4	5
ELA region	648		

July-December 1971

ELA	133	170.5	6
NE	259	252.7	5
ELA region	392		

L.A. COUNTY OUTPATIENT ADMISSIONS

1970 Fiscal year

	Number	*Rate*	*Rank*
ELA	1,292	828.2	8
NE	2,208	1,077.1	4
ELA region	3,500		

July-December 1971

ELA	749	960.3	7
NE	1,216	1,186.3	3
ELA region	1,965		

ADMISSIONS TO BOTH COUNTY AND STATE HOSPITALS

1970 Fiscal year

	Number	*Percentage*	*Rate*	*Rank of region*
ELA	353	2.01	225.9	
NE	557	3.17	271.1	
ELA region	910	5.18	251.6	6

1971 Fiscal year

ELA	986	4.56	631	
NE	1,218	5.63	592.7	
ELA region	2,204	10.19	609.2	2

COUNTY UNITS OF SERVICE (1971 Fiscal year)
Short Doyle Services

ELAMHS

Average monthly caseload	1,418.1
Average monthly admissions	89.5
Total admissions for year	1,074
Average monthly units of service	962.5
Total units of service for year	11,550

Satellite office—Hammel House

Average monthly caseload	215.9
Average monthly admissions	47.2
Total admissions for year	566
Average monthly units of service	289.2
Total units of service for year	3,470

AID TO FAMILIES WITH DEPENDENT CHILDREN
DPSS active caseload as of September 1974

	Cases	*Persons*
ELA	13,815	44,104
NE	4,054	13,813
ELA region	17,869	57,917

Dolores Lucero of Colorado and Julia Soto of Arizona, community workers.

Juan Ramos, of National Institute of Mental Health.

Bernardo Lujan, community worker from Denver.

CHAPTER 6
EDUCATION AND THE CHILD

Introduction

The educational system in any society has a profound influence on the mentality of its citizens; this influence is incalculable in that it may serve to reaffirm established customs, mores, and concepts or to establish new horizons in social, political, or philosophical thinking. The best way to judge the adequacy of any system of education is to determine whether it meets the general needs of the people in a given society.

In this country, the high literacy among whites is evidence that the educational system is highly successful, providing that literacy is measured among whites, who are best served by the system, and not among minorities. Success may thus be judged in terms of how well a given system of education serves the general need. Simply stated, for those who are well served by the present system, it is successful; for those who are not, it is a partial or total failure.

The educational system in this country has, in general, failed to meet the needs of Chicanos. What is worse, it has had a strong negative impact on Chicano children during the years when they are most impressionable. Anglo educators are only now beginning to understand that non-Anglo children face almost insurmountable problems in dealing with an educational system designed for Anglos. Much of the problem stems from inability of Chicano youngsters to relate to the Anglo system of education, which to them is strange and irrelevant. Moreover, many Chicano children have little or no command of the English language at the time they begin their education, many are undernourished, they are castigated for speaking Spanish, and many come from families who are destitute. Under these circumstances, it is small wonder that Chicano children soon lose interest in school or become disenchanted with the idea of continuing their education under such circumstances.

We believe that a system of education designed to take into account the cultural heritage, life style, and psyche of Chicanos will contribute *ipso facto* to their emotional wellbeing. Moreover, it should contribute to scholastic growth commensurate with individual abilities. In addition, such a system would quickly and summarily debunk the so-called problems of mental retardation among Chicano youngsters.

We briefly recount here the system of education for Chicanos in the Southwest, to provide a historical perspective, from the village system of economy to the present-day system. We discuss also the inadequacies of the present educational system and its adverse affect on Chicano children and how the present educational system has labeled thousands of Chicano children. And we make recommendations for an educational model for Chicano children based on a bilingual and bicultural approach.

Historical Perspective

The village economy of the Southwest that developed during the late 17th and early 18th centuries consisted of isolated villages whose economy depended on handcrafts, agriculture, and barter with Indians. In such a setting, each individual possessed about the same knowledge and skills as others of the community. Because a system of public education did not exist at the time, literacy was low.[1]

The village economy system, aside from being vulnerable to the vicissitudes of nature—e.g., drought and insect plagues—was also subject to the influence of Anglos seeking control of farm and grazing lands. With the introduction of the railroad, interest in acquiring land reached a feverish pitch. Along with the land, mercantile industries, including wholesale and retail stores, were gradually taken over by educated Anglos. Because the Spanish-speaking people lacked sophistication in business practices—e.g., ac-

[1]Carey McWilliams, *Brothers Under the Skin* (Boston: Little, Brown and Company, 1964).

counting and price setting—their dealings with unscrupulous merchants often resulted in loss of land as well as of personal possessions. In the process, many Chicanos came to realize that without an education, they could not compete with Anglos and that education was their only recourse.

For many Chicanos the system of education consisted of personal tutoring and matriculation in parochial schools. Tutors were brought from Mexico to Texas and other parts of the Southwest to provide Chicano children with the type of education consonant with the Chicano way of life. Padres at the missions also played a role in the system of education; some of them tutored children in the surrounding areas. In due course the Anglo school system became suspect because it failed to relate to the culture of Chicanos and other Spanish-speaking people. Unlike Anglo girls, for example, girls of the Mexican culture were not encouraged to venture outside their homes to get an education, it being wholly improper to do so in Mexican society.

To whatever extent a Chicano system of education exists in the Southwest, it is fragmented and highly individualized; moreover, there has been a tendency to move toward present-day models of education, which, nevertheless, continue to be irrelevant to the Chicano people. A few schools have attempted to humanize the educational system in this country and to make it more relevant to the life style of Chicanos. Examples include Colegio Jacinto Treviño, in Southwest Texas, El Mercedes in San Antonio, Texas; its counterpart in Fresno, California; Lincoln-Juarez in Fort Worth, Texas; Colegio Tlatelalco in Denver, Colorado; the School of Social Work at San Jose State University, San Jose, California, and Colegio Cesar Chavez at Mt. Angel, Oregon.

To emphasize the dire need to revolutionize the educational system for Chicanos, one need only point out that educational needs of Chicano students are generally catalogued under "special services." One of the most notorious of these "services" includes "special" classes for children who allegedly are retarded. Large numbers of Chicano children have been assigned to these classes because Anglo teachers are unable to understand Spanish or Chicano children. Ironically, thousands of Anglo teachers are employed as specialists in minority education to help youngsters said to be in need of such

Richard Martinez, a WICHE program director. (Now at University of Michigan).

services. This so-called service is not only humiliating to Chicano children, but serves also to instill a sense of inferiority. In most school systems in which there are substantial numbers of Spanish-speaking youngsters, the entire concept of "special services" needs to be re-evaluated and defined. Moreover, wholesale use of specialists in minority education is thought by some to be related to the proliferation of job opportunities for Anglos rather than to meet bona fide needs of Chicano students.

Regarding the American revolution in special education, Dunn stated,

. . . it is recognized that the structure of most, if not all, school programs becomes self-perpetuating. Teachers and state and local directors and supervisors of special education have much at stake in terms of their jobs, their security and the programs which they have built up over the years.[2]

Alluding to the low achievement levels of Chicano students, many authors, including Deutsch, Baca, Hishiki, Kappleman, and

[2]Lloyd M. Dunn, "Special Education for the Mildly Retarded—Is Much of It Justifiable?" *Exceptional Children*, 35, 1968, p. 5-22.

Spaulding,[3] have contended that deprivation of one kind or another experienced by Chicano students before entiring school and during their school years is at the root of the problem. Some of the causal agents identified by these authors include lack of affection, poor peer relationships, low self-esteem, and narrow parental attitudes.

Other authors, including Carter, Ramirez, Rivera, and Cordova[4] have presented a diametrically opposed view, indicating that the problem is not that of a child coming to school without experience, but one with a cultural experience totally different from middle-class children.

Ulibarri described what he feels happens to Chicano children as they enter school for the first time:

The child begins with a handicap the very first day he shows up in the first grade. English is the language of the classroom. He speaks no English, or he speaks inadequate English. He comes from a father-dominated home, and he finds himself in a female-dominated classroom. The Anglo concepts and values that govern and prevail are unintelligible to him. In all likelihood he comes from a low social and economic class, and there he is in a middle-class environment. . . . There is nothing in the atmosphere from which he can draw any comfort.[5]

According to Anderson and Johnson,[6] there is evidence that children of minority ethnicity enter school at a distinct disadvantage and that this disadvantage becomes more pronounced with time. It is not surprising that the appropriateness of placing Chicano children in special classes for the mentally retarded has come under heavy fire. Winetraub expressed concern on this issue in addressing the Council for Exceptional children:

In the last several years, there have been four major cases directed at challenging the legality of placement of children in classes for the mentally retarded on the basis of I.Q. testing which is prejudicial to the children in regard to native language, cultural background and normative standardization.[7]

Other workers[8] have also questioned the propriety of placing children in classes for the mentally retarded, e.g., on the basis of I.Q. testing. They have pointed out that lack of English skills is apt to be at the root of low I.Q. scores. It is important to add that even hunger, which many of these children bring to school with them, affects their performance in the classroom.

There is evidence that the melting-pot concept has been giving way to the concept of cultural pluralism in the public schools. This concept disavows the notion that a child must lose identity with his ethnic peers to succeed in school. Moreover, cultural pluralism encourages respect of the value system of the child's culture, language, and unique learning styles.[9]

---

[3]Cynthia P. Deutsch, "Learning in the Disadvantaged," in *Analyses of Concept Learning*, ed. by H. J. Klausmeier and C. W. Harris (New York: Academic Press, 1966), p. 189–204; Fidel G. Baca, Bilingual Education in Certain Southwest School Districts, unpublished Ph.D. thesis, University of Utah, Salt Lake City, 1956; Patricia C. Hishiki, "Self Concepts of 6th Grade Girls of Mexican-American Descent, *California Journal of Educational Research*, 1969, 20, p. 56–62; Murray M. Kappleman, Eugene Kaplan, and Robert L. Ganter, "A Study of Learning Disabilities Among Disadvantaged Children," *Journal of Learning Disabilities*, 1959, 2, p. 27–33; Robert L. Spaulding, "Common Blocks to Learning," *The Education Digest*, 1966, 32, p. 40–42.

[4]T. P. Carter, "Negative Self-Concept of Mexican American," *Schools and Society*, 1968, 96, p. 217–219; M. Ramirez, "Cultural Democracy: A New Philosophy for Educating the Mexican American Child," *National Elementary Principal*, 1970, 50, p. 45–46; F. Rivera and H. L. Cordova, "Curriculum and Materials for Bilingual, Bicultural Education," *National Elementary Principal*, 2970, 50, p. 56–61.

[5]Sabine Ulibarri, cited by Stan Steiner, *La Raza: The Mexican Americans* (New York: Harper and Row, 1969), p. 214.

[6]J. G. Anderson and W. H. Johnson, "Stability and Change among Three Generations of Mexican-Americans; Factors Affecting Achievement," *American Education Research Journal*, 1971, 8, p. 285–309.

[7]F. J. Weintraub, Recent Influences of Laws on the Identity and Placement of Children in Programs for the Mentally Retarded, Report to the Council for Exceptional Children, 1971.

[8]Fidel G. Baca, Bilingual Education in Certain Southwest School Districts. Unpublished Doctoral dissertation, University of Utah, Salt Lake City, 1956; Lloyd M. Dunn, "Special Education for the Mildly Retarded—Is Much of It Justifiable?" *Exceptional Children*, 1968, 35, p. 5–22; R. N. Elliott, H. Grossman, and W. C. Morse, "The Exclusion of Children from School, the Unknown, Unidentified, and Untreated," *Council for Exceptional Children Special Report*, ed. by J. Regal, 1972.

[9]M. Ramirez, "Cultural Democracy: A New Philosophy for Educating the Mexican American Child," *National Elementary Principal*, 1970, 50, p. 45–46.

Task Force work begins. Javier Saenz of Utah examines a drawing of the proposed Colegio Jacinto Treviño in the form of an Aztec pyramid.

Results obtained from studies of bilingual education indicate that well-balanced bilingual children are superior to monolingual children in verbal and nonverbal techniques. Very likely, application of cultural pluralism is developing elementary curricula would benefit all students. Rivera and Cordova state that cultural pluralism would increase

. . . the equality of educational opportunity for the Mexican-American and the quality of educational content for *all* students. What benefits Mexican-Americans educationally also benefits the total educational system and thereby improves group interaction in our society.[10]

The benefits that cultural pluralism can impart to the existing educational system through bilingual education is obvious if recognition is given to the fact that the Anglo social system is highly competitive and strongly geared along material lines. In a strongly materialistic society and competitive system of education, little attention is given the individual. Maturity is gaged in terms of how quickly the young can minimize and/or sever family relationships. All this is contradicted by the highly humanistic character of the Chicano culture, in which education is seen in terms of individual life styles, habits, needs, and characteristics.

Educational Plan

Since the Spanish language is a principal component of the Chicano culture and heritage, the educational plan outlined herein advocates that Spanish be taught in primary and secondary schools and that a bilingual, bicultural system of education be implemented in all areas of the country where Chicanos reside. Other recommendations call for:

1. Abolishment of I.Q. testing for Chicano children who are culturally and/or linguistically different from children of the dominant society but have the same potential for learning.

2. Implementation of innovative and relevant testing techniques to meet special needs in given areas. Testing should include examination of the child's home environment, including cognitive skills, life style, and mores, all of which should provide a down-to-earth evaluation of the child's educational problems. It is extremely important that Chicano personnel make home contacts and do the testing and evaluations.

The Las Vegas Conference— June, 1973. Local talent is drawn in during the breaks between sessions.

[10]F. Rivera and H. L. Cordova, "Curriculum and Materials for Bilingual, Bicultural Education, *National Elementary Principal*, 1970, 50, p. 46–61.

3. Reassessment of language skills among Chicano children to provide necessary language training for pre-kindergarten and kindergarten children in Spanish. Well-qualified Chicano instructors, i.e., professionals or specially trained individuals in the field, are recommended. The plan should give evidence that this has been started within six months from the time of implementation.

4. Initiation of reading programs and/or clinics in Spanish. After children have acquired basic reading skills, instruction in a second language should be initiated.

5. Establishment of bilingual, bicultural programs of education from pre-kindergarten or kindergarten through college, using college volunteers with or without college degrees, other students, and community people who qualify for the work.

6. Lesson plans on Chicano culture and history following models established by Colegio Jacinto Treviño, Colegio Cesar Chavez, and San Jose State University.

7. Establishment of a governing citizens' council to establish curricula at local, state, and regional levels. Such a council or policy board would be charged with responsibility for seeing that equal educational opportunity guidelines are followed and implemented.

8. Establishment of child advocacy boards to see that mental health centers provide consultation and education where indicated.

9. Monitoring of educational theories and practices so that modifications are made as community needs change.

10. Consultation and education sections to be established in the mental health centers, where personnel address themselves to child advocacy programs in the educational system. It is recommended that this be done in conjunction with local schools and consultation with community groups.

In implementing recommendations, resistance is expected from the Anglo population similar to that encountered by other who have tried to effect change.

Alicia Noriega opens the conference at Las Vegas, New Mexico. She is the historian, the keeper of tangled threads which led to this gathering.

Lieutenant-Governor Mondragon, of New Mexico, welcomes the delegates from eleven states to Las Vegas, New Mexico.

Eloy Apodaca keynotes the conference. "Qualifications"—that's the code name for Anglo rules we must learn to cope with if *our* culture is to survive. . .

CHAPTER 7
LEGAL RECOURSE FOR PROCUREMENT OF MENTAL HEALTH SERVICES

It is well known that mental health services available to Chicanos and other minorities in this country are generally inadequate. Even services for children of nursery-school age, university students, welfare and social services recipients, and the sick and infirm are inadequate. To a considerable extent, the inadequacies are attributable to the dearth of individuals from Chicano communities serving on policymaking bodies, e.g., school boards, welfare agencies, and hospital boards. Even the language used to describe or offer available services may be, and often is, inadequate, considering that many Chicanos do not read English and speak only Spanish.

Since few Chicanos have jobs with policymaking roles, the situation continues to go unchanged. Even the location where services are available is important. Those beyond physical reach, for example, might just as well be nonexistent. There is legal recourse, however, for improving the quality and availability of the multiplicity of services needed by the community.

Many agencies, schools, hospitals, and universities receive federal monies and/or assistance in the form of loans, grants, and contracts. All are obliged by federal law to see that delivery of services to those in need proceeds in a nondiscriminatory manner. Unfortunately, many institutions have seen fit to ignore the law; in other words, legal obligation does not consistently translate into action. It is therefore necessary for Chicanos and other minorities to familiarize themselves with the law in order to determine whether institutions are meeting their obligations in terms of making readily available the multiplicity of services needed by people in the community. It behooves us to understand, moreover, that any agency or institution that receives federal monies to support any segment of its overall program is obligated to provide equal and ready access to all services in an equitable manner to all who need them.

Title VI of the 1964 Civil Rights Act states that "no person in the United States shall on the grounds of race, color, or national origin, be excluded from participation in, be denied the benefits of, or be otherwise subjected to discrimination under any program or activity receiving federal financial assistance from the Department of Health Education and Welfare (DHEW).

This law is administered in the DHEW by the Office of Civil Rights (OCR) and is applicable only to federal grantees, as opposed to federal contractors. (The ten Offices of Civil Rights (regional offices) are indicated on the map at the end of this chapter.)

Prior to receiving federal monies, officials of any institution must in writing agree to comply with Title VI and the regulations promulgated by DHEW. Any agency or institution that fails to comply with the law may have federal assistance discontinued.

Although the OCR is charged with the job of conducting compliance reviews, the most efficacious manner of settling disputes regarding delivery of services is to lodge a formal complaint setting forth the charges and names of plaintiffs. The OCR is sensitive to formal complaints of noncompliance and should be consulted. One should bear in mind, however, that it is better to negotiate or correct complaints than to have federal monies rescinded, since the latter results in termination of all needed services. The object of filing a complaint with the OCR, then, is to force all institutions receiving federal monies to comply with the law, and to see that all pertinent regulations are enforced.

Complaint Procedure

In order to file a formal complaint with the OCR, the plaintiffs must set forth, in writing, allegations of discrimination based on race, color, or national origin. If the plaintiff wishes to remain anonymous, the law provides such an

option. A complaint may be more efficaciously arbitrated, however, if the plaintiffs sign the complaint and include all necessary documentation to support the allegations.

Plaintiffs should be prepared to follow through on all complaints filed with the OCR by suing the institution or agency named in the complaint, as well as the OCR, if the discrimination is not corrected. It took a court order, under Adams vs. Richardson in 1973 to force the DHEW, as well as the OCR, to take action against 10 states that continued to operate a dual system of higher education after DHEW/OCR directed the states to cease such practices.[1] Clearly, a complaint filed with the OCR, regardless of the outcome, is important in the total effort to enforce the law.

Examples of Discriminatory Practices

The following are considered to be discriminatory: (1) applying different standards to determine eligibility for services, (2) outright denial of services, (3) placing service facilities in locations not readily accessible to recipients, (4) maintaining segregated services, (5) refusing to grant equal privileges to the staff of any facility, (6) failing to use languages other than English where needed to provide services, (7) using hiring practices that affect the quality of services and their availability, and (8) denying individuals who are members of planning or advisory groups the opportunity to participate in the governance of programs in which they are participants.

Roberto Castro, addictions worker from Los Angeles, pouring forth the lively words he is known for. . .

[1]United States Commission on Civil Rights, *The Federal Civil Rights Enforcement Effort—1974*, Vol. III, *To Ensure Equal Education Opportunities*, p. 370.

DHEW REGIONAL OFFICES FOR CIVIL RIGHTS (SEE MAP)

Region I
RKO General Building
Bulfinch Plaza
Boston,
Massachusetts 02114
617-223-6397

Region II
26 Federal Plaza
New York,
New York 10007
212-264-4633

Region III
Gateway Building
36th and Market Streets
Post Office Box 13716
Philadelphia,
Pennsylvania 19104
215-597-772

Region IV
50 Seventh Street, N.E.
Atlanta, Georgia 30323
404-526-31[illegible]

Region V
309 West Jackson Blvd.
Chicago, Illinois 60606
312-353-7742

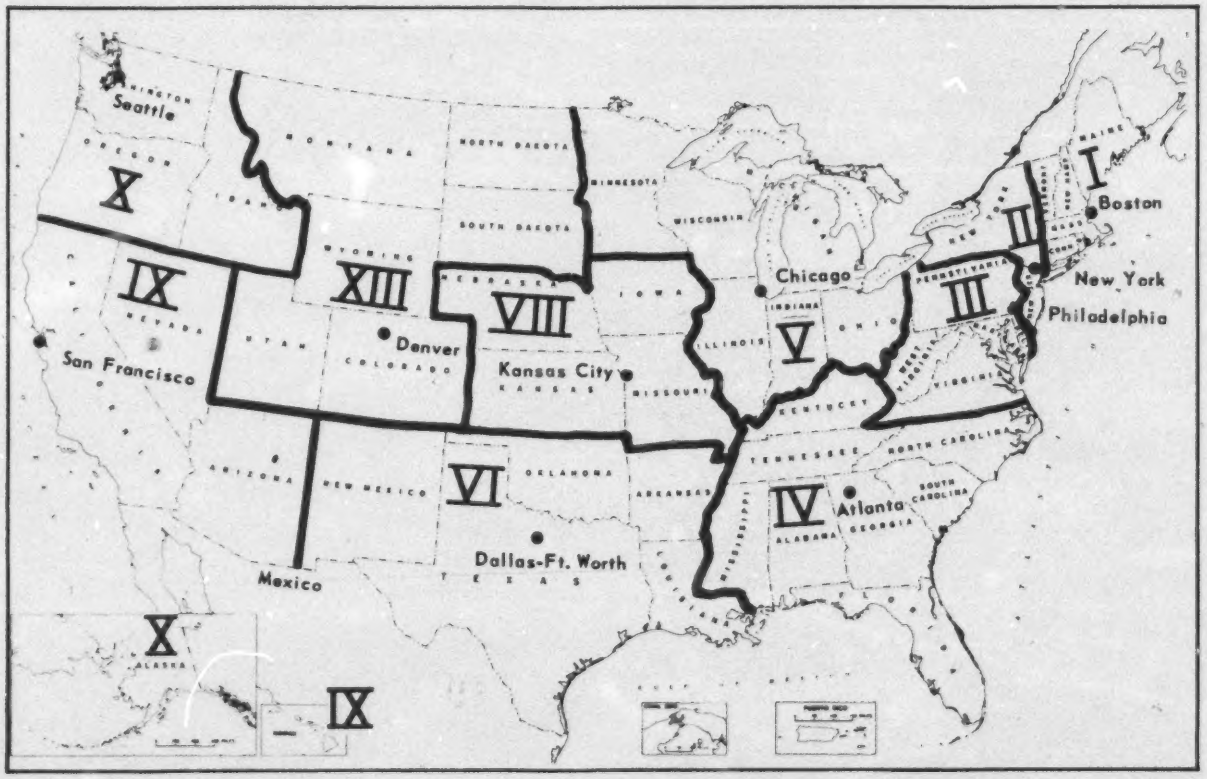
Region VI
1114 Commerce Street
Dallas, Texas 75202
214-749-2741

Region VII
Federal Building
601 East 12th Street
Kansas City,
Missouri 64106
816-374-3667

Region VIII
Federal Building
1961 Stout Street
Denver, Colorado 80202
303-837-4345

Region IX
Phelan Building
760 Market Street
San Francisco,
California 94102
415-556-8586

Region X
608 Arcade Bldg. M/S 616
1321 Second Avenue
Seattle, Washington 98101
206-442-0473



Armando Morales with new data and documentation from East Los Angeles.

Final day: a panel of Federal consultants try to field questions from the floor. Roberto Duron of San Francisco and Sam Brito of Dallas are identifiable on the left. Floyd Martinez from NIMH in Washington, D.C. is on the extreme right.

CHAPTER 8
SUMMARY

A. Criteria For Evaluating Services

It is easy to extract from the task force work described above a vast list of recommendations, some major, some very specific, some so broad as to appear in each report. Rather than print such a list—which any reader may develop for himself, each with priorities that fit his own area—the editorial committee decided to attempt to extract from the work as a whole the most *fundamental criteria* it could identify to serve as a basic guide for evaluating the adequacy and effectiveness of mental health delivery programs that serve the Spanish-speaking/Chicano communities of the Southwest.

These criteria should be used by *any persons*—including citizens, clients, students, and mental health workers—who wish to examine or test the adequacy of a mental health service that includes numbers of our people in its "catchment" area. We hope that not only citizens but also federal, state, and local mental health authorities will become familiar with these criteria and use them. They are not hard to understand; perhaps they are even self-evident. Nevertheless, history suggests that even the simplest things may be worth spelling out on paper in brief detail:

1. Is the program engaged in preserving and understanding the *unique nature of the Chicano familia*? Does the program recognize its particular importance to the Chicano client, who seldom, if ever, is just a lone individual with purely individual problems and responsibilities?

2. Does the program utilize the indigenous Chicano community as a *source of manpower* and *expertise*?

3. Has the program taken steps to *sensitize its staff* to the unique values and life styles of the community residents it tries to serve? Books or an occasional film will not be enough. Chicano communities vary throughout the Southwest. Real local expertise is needed—competent in-service training should be conducted by competent representatives from whatever communities, whether stable and traditionally rooted or in change and incessant movement, the program should be serving.

4. Does the program provide an atmosphere conducive to *personalized, respectful concern* for the Chicano client from initial contact through actual services? The Chicano culture profoundly rejects the notion that people should be thought of as products, outputs, labels, or computer numbers. No matter the size or efficiency of an agency, the people within it should relate to one another personally and with mutual respect.

5. Does the program staff understand, accept, and promote the concept of *cultural pluralism*? We believe it is an absolute requirement that staff learn that forcing cultural assimilation has nothing whatever to do with enhancing positive mental health. We believe also that to really understand this and carry out services in a manner that advances cultural pluralism calls for an informed commitment and effort, which will not be achieved at a snap of the fingers.

6. Has the program developed one or more service components designed to reach Chicanos in their own environment? That is, are *effective outreach services*, rooted in actual Chicano communities, part of the program? By "effective" we mean easily accessible, inviting, competently staffed, bilingual, responsive to local needs, and a source of pride to citizens of the local community.

7. Are the techniques used for *psychological assessments* and the *labeling* of problems in living appropriate for the Chicano population being served? Are they genuinely effective in rendering useful service to clients rather than generating confusion, wasting time on irrelevancies, or causing permanent damage, as in the case of reports for school-system files?

8. Is there positive evidence that the program has developed and sanctioned resources to carry out *social advocacy activities* on behalf of Chicano residents? A mental health program has a unique opportunity to gain knowledge of the

manner in which social agencies, law enforcement groups, school systems, even institutions of finance and industry affect local populations. It has, therefore, a corresponding responsibility to use some of this knowledge in assisting the community—through consultation and education—to better handle its problems and more effectively deploy its available resources.

9. Finally, are there adequate, easily understood, widely comprehended *channels* through which the community may communicate with the mental health program, make its needs known, and effectively influence the manner in which those needs are met? What this really means is, does the program *share its power and decision making* with each of the populations it is trying to serve? Power is many things. It may be thought of in terms of boards and the places where policy is made or changed. It may be conceived of in terms of staff, financial resources, the deployment of buildings, or the manner in which clients are assembled or grouped for types of service. At its simplest, it may involve the sharing or witholding of information. Every Chicano community has a right not only to adequate mental health resources but to the sharing of the power through which those resources are shaped and guided.

B. Some Areas for Future Action

Again, almost every page of this report bristles with areas for future action, which will suggest themselves to a reader familiar with his own community and the services which may or may not exist to assist its mental health. We seek here only to identify some broad topics that would seem to apply throughout the Southwest, perhaps throughout much of the nation.

1. Research

There are still few Chicano scholars to address our needs for better information about what has really been happening to us in recent centuries and in what directions we are now flowing as a people. There are more now than there were, however, and some are trained in the so-called behavioral sciences. From these, many of them very young and just emerging from the graduate schools, we need fresh information about

a. The *indígeno heritage* that has profoundly helped to shape us but about which so much less is understood than our Spanish and Mexican roots. We need a perspective for theory building, which may provide better strategies for both physical and mental health services. We acknowledge the importance of the indigenismo in all of us—but we know so little compared to what we sense.

The final writing begins. Elsie Sanchez, chairperson of the implementation committee elected at Las Vegas, convenes the scribes.

b. The use of *folk practitioners* in our barrios. Even our Anglo brethren have often heard, by now, of curanderos, curanderas, brujas and the like. To what extent are folk practitioners actually used? When are they best used? What happens when they are cultivated as mental health allies—or actually added to the staffing of a mental health program?

c. The implication of existing *testing instruments* for assessing psychological and/or

educational needs. Where improved instruments or "culture-free" tests are said to have been developed, we need research by our own scholars to validate such claims and again to assess how such instruments are in fact to be used.

d. How do our various communities—those caught up in massive change as well as those that remain rooted—*cope with problems in living now*? We still need the most elementary research to identify how we cope with such problems and how we have survived as a culture in the face of so much pressure to assimilate or to feel inferior. We need theory and terms and a body of knowledge sufficient to constitute a *Chicano theory of mental health*. Until we have it, we lean upon Anglo and Viennese theory, with results that range from the dreadful to the absurd.

Eloy Apodaca arrives at Peaceful Valley, Colorado, complete with his traditional brief case.

Arnoldo Solis, pioneering Chicano psychiatrist from the Mission District in San Francisco, writing.

2. Fresh Models of Service:

a. *Community-based monitoring systems*—This phrase has been common to many of our citizen groups in recent years, but we fear that few really effective methods exist whereby a community may keep watch on the agencies that purport to serve it. We need better methods, we need to share these methods, and we need to know how to keep them operating.

b. The *one-roof concept of total health care*, whereby facilities for promoting mental health are housed side by side with those concerned with physical health, seems to us often the organizational choice if Chicano families are to be served in ways that will make them feel whole instead of fragmented and dissected by competing agencies. Different versions of the one-roof concept are now springing up here and there,

some of them huge and perhaps dysfunctional. We need to compare these versions and find which are effective.

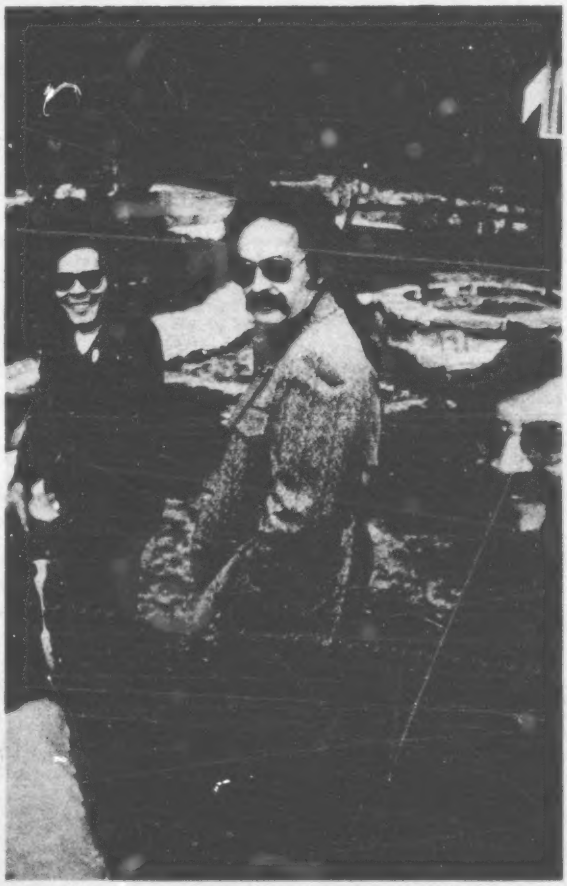
c. Our *paraprofessional workers* need workable systems for gaining *usable accreditation and education*. We are well aware that in contrast to services in white middle-class suburbs, which rely almost entirely upon highly credentialed professionals, many of the services for the Chicano both now and in the future will be based upon the paraprofessional, the "new careerist," the "community worker," etc. We do not lament this, we applaud it. We want our own people, who really have expertise in the life of the barrio, to serve our own needs. But we are also keenly aware that many of these essential workers would not object to earning someday the salaries of physicians or certified psychologists or social workers, and to have a title. The career and education ladders that most paraprofessionals have been assured will be developed do not, in fact, exist in many areas as yet. No matter how skilled and experienced he may be, a good paraprofessional cannot leave at will the agency that first hired and trained him in order to seek a better job elsewhere or in a different community. One cannot do this until one has a usable piece of paper, a certification or license that attests to one's qualifications. Nor can the paraprofessional easily work toward higher degrees—assuming he wishes to do so—until he has usable credits and definite ladders to try to scale. It is shameful to abandon today's paraprofessionals in dead-end jobs and rely solely upon tomorrow's crop of future professionals emerging from colleges.

3. Use of the law to bring needed change

Very slowly, but sometimes usefully, the legal structure of this country adapts to social needs and can be harnessed by citizens and professionals alike to bring change. Specifically, we would alert those who work for better mental health to these possibilities:

a. *Bilingual education* and requirements for *bilingual staff* in programs serving non-Anglo populations are beginning to appear under federal and state laws. Such laws must be known and then monitored by citizen groups if they are to be implemented.

b. *Civil rights laws and civil rights commissions* (including the federal Office of Civil Rights, with its western regional representatives in Dallas, Denver, San Francisco, and Seattle) should be carefully studied to determine if they have had a maximum impact in restructuring programs, policies, and staffing.



A group of final editors. Ricardo Ontiveros on the left, Efraím Lugo on the right. In center is the final editor of this volume, Dr. Rubén Durán of Pullman, Washington.

APPENDIX A.
NOTES ON PROCESS

More than 400 names appear one or more times on the lists below. We make no claim that these lists are all inclusive, nor that the spellings are invariably correct, nor that the degrees for those who list them are up to date, nor that the states of residence are still current. These are the names as they were recorded on official rosters. Almost every major event, however, included participants who came on their own, often at the last minute, who shared expenses and rides with official delegates, and who were never counted, or people who just never signed the official roster but instead rushed to take part in the work of the conference.

But we regard each name below as representing not only a participant but also a *contributor* to this plan. Not all the persons below would agree with everything in this final document. Some may not even have suspected they were helping to produce such a document. And a few might legitimately claim they cannot be held responsible for the contents and ideas found herein. The conferences and task force meetings listed below produced enormous controversy and a wealth of conflicting opinions. Everyone named below—and a great many whose names are not on our surviving rosters—contributed to the process that resulted, for better or worse, in this plan.

This was not a process that relied upon learners listening to experts. It was, instead, an attempt to bring together workers from agencies in the field and citizen leaders; to crystallize their thinking upon actual issues and needs; to submit such thoughts, once crystallized into papers, to larger groups of mental health workers and citizen leaders for fresh analysis and controversy; and finally to let an editorial committee read the final reports and tape transcriptions, and reduce them to a coherent publication.

This is not the usual way to record knowledge or do research. It is unwieldy at times, and certainly not as neat as allowing a few established experts to deliver formal papers to passive audiences. But it is one way to tap the thinking of a great many people, and it is one of the best methods there is for helping people who don't know one another *to learn* from each other and to fortify their own thinking. It also produces some magnificent parties in the evenings, some friendships and alliances that might not otherwise have ever had a chance, and some lively controversy—fantastic arguments!

This process grew out of the Goleta Conference (often called the "Santa Barbara meeting") of June 10-12, 1970. It was billed as a conventional conference with formal speakers,[1] but it was not a very conventional experience for those who took part. Hemmed in by an almost constant police-student riot outside the meeting place, and perhaps given added cohesion by three solid days of discussions, firey speeches, firier parties, and the discovery that Chicanos from nine different Western states had a great deal in common after all, this group urged a follow-up conference upon WICHE (Western Interstate Commission for Higher Education) and NIMH (National Institute for Mental Health) for the next fall or spring. Perhaps the focus could be on the *barrio*?

February 1971

At a planning session for the proposed follow-up conference in East Los Angeles, Paul Sanchez and Richard Martinez suggested a conference in Boulder, Colorado, instead, to focus not on the barrios but on the nature of the federal system, of HEW and NIMH and their regional Offices, and on interstate compacts such as WICHE.

June 3-5, 1971

A confrontation-style learning session was held in Boulder, with representatives from HEW, NIMH, and WICHE's available staff being held to account, somehow, for the manner in which federal and state governments operate, give grants, set priorities, etc. Thirty-six Chicanos took part in this event. During a final caucus, a

[1]Stanley W. Boucher, ed., *Mexican-American Mental Health Issues* (Boulder, Colo.: WICHE, 1970).

nine-member Chicano Mental Health Advisory Committee was elected to help plan future training sessions, using portions of WICHE's grant for continuing education in mental health.

Alicia Noriega, specialist on problems of alcoholism, of the aged, of East Los Angeles in general.

July 24-25, 1971

The Chicano Advisory Committee met at WICHE in Boulder, Colorado. Narciso Aleman from the Colegio Jacinto Treviño in Texas proposed that instead of traditional conferences graced by experts, a core group of Chicanos be assembled to develop a Chicano Plan for Mental Health. The document could emerge in its final form from a large interstate conference. Much learning and interchange would occur—"continuing education." But a product would result, something tangible.

September 10, 1971

Hosted by Leo Romero in Albuquerque, twelve people met to lay the groundwork for a Chicano Plan for Mental Health. Armand Sanchez of California was skeptical—there are too many conferences in which people set grandiose goals and talk but produce nothing usable for the world of action. Emma Chavirra feared that community representation would be overlooked and that professionals would dominate, as they tend to dominate all such conferences. Eloy Apodaca also championed this view but agreed to chair the group and try to build a grass-roots process. Funds were scarce, and it was agreed that regional offices of HEW in the West should be tapped for possible funds, as well as NIMH and WICHE.

December 1971

A new organization known as COSSMHO (Coalition of Spanish-Speaking Mental Health Organizations) was being formed to link groups throughout the United States. It was rumored to have a large pot of money. Its initial steering committee was gathering in Los Angeles and a joint meeting was arranged. It was discovered that while much common ground existed, COSSMHO was still organizing and had no funds as yet to undertake either conferences or the production of a plan. Following the joint discussions, the plan group met at the East Los Angeles Mental Health Services building. Leo Romero proposed that six task forces be created. Each would work by mail and in occasional face-to-face small groups to produce a position paper on a major topic. These papers, once finished, would be takeoff points for members of an eventual large conference of workers and consumers. The task forces were: I. La Familia, II. The Urban Barrio, III. Migrants and Rural Areas, IV. The Child and Education, V. The Addictions, including Alcoholism, VI. The New Breed of Human Service Worker.

Later it was decided that item VI was really part of each of the other five topics and could be part of each task force's agenda.

The fact that WICHE could help with occasional small-group meetings but that no one had money for the proposed final conference was discouraging to some.

March 3-4, 1972

Twenty-two task force members met in Albuquerque, again hosted by Leo Romero. The work was slow and uncertain. Members felt isolated, swamped by job pressures at home, worried by the vagueness of chances that what they were doing would ever have an audience. Eloy Apodaca reorganized the group, preserving the task force concept but creating state coordinators in each of eight states. Each coordinator was to meet locally with other compadres to exchange ideas and develop recommendations for the position papers. If no local organizations of Chicano mental health workers existed, perhaps these discussions could lay groundwork.

Meanwhile, Leo Romero asked permission from the group to temporarily withdraw. All his energies had to go into organizing a summer conference on total health services for the barrios.

June 30-July 1, 1972

Thirty-six people met in Salt Lake City, hosted by Javier Saenz. A vast amount of writing went on, on manuscript pads, on great sheets taped to the walls and ceilings, in dictation into tape recorders for later transcription. There were complaints that state coordinators were too aloof from the writers. The coordinators were split off to join the writing task forces. Fears that planning decisions were not being made forced renewed gatherings of the coordinators. As papers and wall graffiti were read together, it became apparent that there was great overlap, huge areas of consensus between the task forces, but much writing and crystallizing remained to be done. Deadlines for final versions, to be written at home, were set. It was far and away the most productive meeting yet, if paper and words in semi-organized form are measures of productivity. There were complaints about the food—Dolores Lucero was rushed to the hospital with acute food poisoning. She recovered a day later.

Colegio Cesar Chavez at Mount Angel, Oregon. Javier Saenz on the left, Sarah Baca of Albuquerque in center facing camera. Rubén Durán and Pablo Ciddio are standing.

August 12-13, 1972

State coordinators met in Seattle with regional office consultants to seek funds for the grass-roots conference that would cap all the work on position papers. Modest funds were promised from each of the four regional offices serving the West (Dallas, Denver, San Francisco, and Seattle). The possibility of funding from the Minority Center at NIMH in Washington, D.C. and from WICHE for a core group from each western state engendered optimism for a fall conference.

December 18-19, 1972

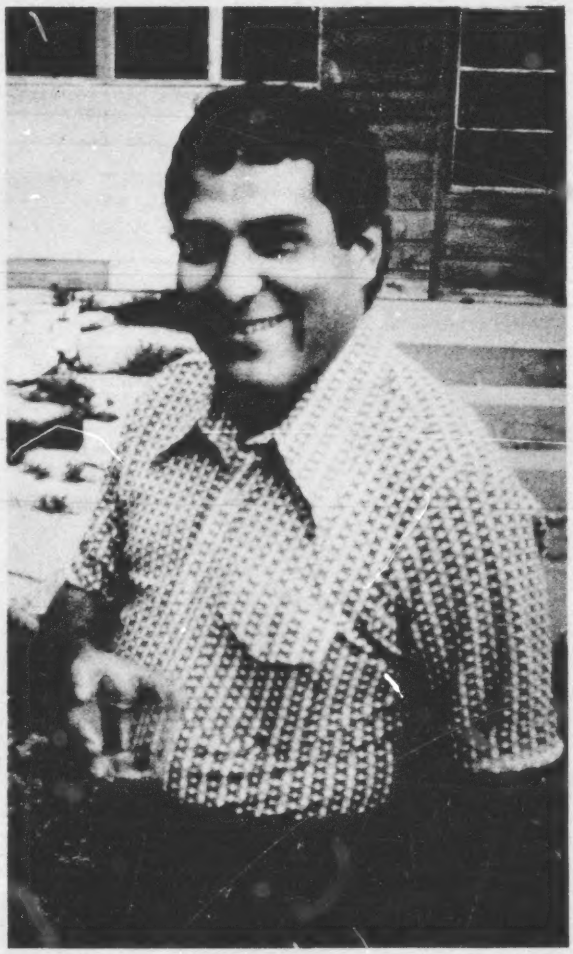
Funds were still uncertain, but enough were promised for at least a modest conference. Twenty-one participants met at Tucson, hosted by Gil Sanchez, to plan the "big" conference. Ignacio Rodriguez and Roberto Duran of the Federal regional offices were able to promise regional funds. Stan Boucher committed WICHE. Others would work on Washington, D.C. An ambitious conference was mapped out. The Texans suggested New Mexico, a central site for Chicanos.

June 13-15, 1973

More than 250 people (of whom 170 signed the roster) assembled in Las Vegas, New Mexico. New Mexico Highlands University provided inexpensive dorms and meeting rooms. Roberto Mondragon, lieutenant-governor of New Mexico, opened the conference, along with Dr. Frank Angel, president of the university. Eloy Apodaca and Armando Morales also delivered major addresses. But the bulk of the conference work was done in five large task force groups, which took apart the position papers and produced thousands of words of fresh comment. Spanish-speaking secretaries recruited by the university transcribed all sessions. Each task force selected a scribe for final preparation of its work. Elsie Sanchez replaced Eloy Apodaca as chairperson of the implementation committee. Arnoldo Solis, M.D., was selected as chief editor; the task force scribes were to serve as an editorial committee.

March 15-16, 1974

At Colegio Cesar Chavez near Mount Angel, Oregon, 22 persons met to examine the papers and tapes. (During the fall, conference materials were in limbo somewhere in Las Vegas. Finally, Eloy Apodaca—recovered from a motorcycle accident—made a personal trip, contacting key people to retrieve the tapes and get them to WICHE for reproduction.)



Javier Saenz, believing the publication may actually get completed. . .

June 8-9, 1974

The implementation committee met at Peaceful Valley, Colorado, to examine proposed final drafts. Fireworks erupted over the question of prematurely exposing to governmental consultants work developed within the barrios and clearly at odds with conventional theory. The group met with Rodolpho Sanchez, chairman of the now well-organized COSSMHO. He welcomed any contributions from any Chicano

organizations. The meeting ended with high praise for the work of Arnoldo Solis—a first attempt to prepare an overall draft of the Chicano Plan.

July-February 1974-75

Much still had to be done. Whole sections still required rewriting, insertion of footnotes, etc. Finally Rubén Durán, the member most experienced in dealing with publishers and preparing manuscript copy, took the entire bundle of texts and notes into his household, occasionally transporting it like a monkey on his back to Mexico and finally completing a usable text in February 1975.

March 15-16, 1975

Postponed once by Rubén Durán's illness and Elsie Sánchez' surgery, the implementation/editorial committee met for the final time in Denver, approved final copy, and urged publication. There are many more scholars now, and more organizations. This plan, carried from city to city for three years, now joins them.

Arnoldo Solis, in the Colorado Rockies, thinking. . .

Elsie Sánchez, now a Civil Rights investigator in Dallas, looking relaxed and benevolent and even tolerant of those who are slow.

The future: an ancient people, their children very much a part of a new world now developing. . .

APPENDIX B.
Master Participant List

Mexican-American Mental Health Issues: Present Realities, Future Strategies

June 10-12, 1970

Place: Goleta, California

ARIZONA

Manuel O. Dominguez, B.S.
Executive Director
Valle Del Sol Institute
2905 E. Flower Street
Phoenix

Valdemar Gonzalez, M.S.W.
Chief of Social Services
St. Lukes Hospital
2929 E. Desert Cove
Phoenix

Alfredo Gutierrez
1017 Hadley
Phoenix

William Maytorena, Jr., B.S.
Community Liaison Director
University of Arizona Medical School
Department of Community Medicine
Neighborhood Health Center
Tucson

Juliet Ruiz, A.C.S.W.
Psychiatric Social Worker
St. Lukes Hospital Mental Health Center
P.O. 336
Phoenix

Gilbert A. Sanchez, M.S.W.
Program Coordinator
Tucson-Southern Counties MH Centers
P.O. 5481
Tucson

Julia C. Soto
Planning Aide
Committee on Economic Opportunity
2030 E. Speedway
Tucson

CALIFORNIA

Juan D. Acevedo, M.A.S.
Director
Narcotics Prevention Project
507 Echandia
Los Angeles

Robert Acosta
37272 Maple Street
Fremont

Edward Aguirre
League of United Citizens to Help Addicts
920 S. Atlantic Blvd.
East Los Angeles

Manuel Alvardo
1435 Grove Way
Hayward

Gloria Arellanes
Administrator
El Barrio Free Clinic
1978 Brooklyn Avenue
Los Angeles

Angie Avila
511 Crosby Street
San Diego

Fernando Chavez
910 S. Atlantic Blvd.
Los Angeles

Elias Chico (Deceased)
East Los Angeles
Health Task Force
Los Angeles

Dr. Uvaldo Soto Dunbar
Community Mental Health Psychologist
ELA Mental Health Service
512 S. Indiana Avenue
Los Angeles

Alejandra J. Ebersole, M.S.W.
Psychiatric Social Worker
Sacto Medical Center—
Mental Health Clinic
4430 V Street
Sacremento

Alicia Escalante
Welfare Rights Organization
2222 E. First Street
Los Angeles

Ernesto Galarza
1031 Franguette Street
San Jose

Alejandro Garcia, M.S.W.
Psychiatric Social Worker
Community Services Division
California Department of Social Welfare
Sacramento

Dolores Garcia
Santa Clara County MH Center
645 Bascam Avenue
San Jose

Garl Hudson
4813 Greenbrier Avenue
San Diego

Armando Morales
1960 Plancentia Avenue
Hacienda Heights

Alicia Noriega
East Los Angeles
Mental Health Service
Los Angeles

Gregory Ochoa
Spanish Language Counseling Center
1426 Main Street
Venice

Ricardo G. Ontiveros, B.B.A.
Executive Director
Social Action Research Center
1013 Harrison Street
Oakland

George Ortiz
2462 Mendocino
Santa Rosa

Orpha A. Ortiz
President
Los Angeles Retarded Children Assoc.
P.O. 63174
Los Angeles

Quirino Parra
2125 19th Street
Sacramento

Manuel G. Rodriguez
Special Consultant
Juvenile Delinquency Prevention
Social Action Research Center
1013 Harrison Street
Oakland

Octavio Romano
Assistant Professor
Department of Behavioral Science
School of Public Health
University of California
Berkeley

Flora Rubalcava
Community Aide
State Services Center
6951 Glidden Street
San Diego

Paul Sanchez
Director
Graduate Department of Social Work
San Jose State College
San Jose

Maria A. Sardinas, M.S.W.
Assistant Professor of Social Work
San Diego State College
School of Social Work
San Diego

Faustina Solis
Project Director
Fain Workers Health Service
California Department of Public Health
Berkeley

COLORADO

Tony Chavez
Caseworker IV
El Paso County Welfare Department
27 E. Vermijo Avenue
Colorado Springs

Josephine Gabaldon
Mental Health Aide
West Side Neighborhood Health Center
990 Federal Avenue
Denver

Orlando L. Martinez, B.A.
Probation Supervisor
12th Judicial District
Alamosa

Luis B. Medina, M.S.W.
Assistant Professor
Department of Social Work
Southern Colorado State College
Pueblo

Salvador Ramirez
Assistant Professor
Department of Sociology
University of Colorado
Boulder

Albertino A. Salazar, M.S.W.
Social Worker IV
Colorado State Hospital
Pueblo

John Ventura
Director for Community Organization
Auraria Community Center
1212 Mariposa
Denver

MARYLAND

Warren C. Lamson, M.S.S.W.
Assistant Chief
Continuing Education Branch
National Institute of Mental Health
5454 Wisconsin
Chevy Chase

Dr. Juan Ramos
Special Assistant to the Director
Office of Program Liaison
National Institute of Mental Health
5454 Wisconsin
Chevy Chase

NEW MEXICO

Dan Archibeque
Mid-North Valley Community
Service Center
1620 Griegos Rd., N.W.
Albuquerque

Josie R. Candelaria
Social Worker
Assistant Director
Southern Broadway Opportunity Center
2119 Broadway, S.E.
Albuquerque

Helen DeHerrera
Health and Social Service Department
117 Trumble, S.E.
Albuquerque

Dr. Peter J. Marquez
624 Lomas Blvd., N.W.
Albuquerque

Frank Otero
Bernalillo County CMHC
2600 Marble, N.E.
Albuquerque

Leo Romero (Deceased)
Psychiatric Social Worker
Bernalillo County CMHC
600 Marble, N.E.
Albuquerque

Julie M. Sisneros, B.A.
Coordinator of Alcohol
and Drug Abuse Programs
Southwest Mental Health Center
1501 N. Solano
Las Cruces

Ernest Suazo
Program Associate
Continuing Education
Department of Psychiatry
School of Medicine
Albuquerque

OREGON

Clemente Atkinson
Area Supervisor
Opportunity Center of the Valley
Migrant League
840 Jefferson Street, N.E.
Salem

TEXAS

Mariano Aguilar
1609 S. Cibolo
San Antonio

UTAH

Rose M. Van Diggelen
Case Aid
Youth Services Program
211 E. 3rd Street
Salt Lake City

Javier Saenz
Clinical Director
Group Therapy Program
Mental Health Center
156 Westminster Avenue
Salt Lake City

WASHINGTON

Anibal Mejia, B.A., B.S.
Executive Secretary
Governor's Secretary
Governor's Committee
on Mexican-American Affairs
130 6 Capitol

Fred O. Monoya, M.S.W.
Psychiatric Social Worker III
Department of Institutions
15 K N.E.
Ephrata

IMPLEMENTING ORGANIZATIONAL CHANGE IN THE WEST

June 3-5, 1971

Place: Boulder, Colorado

ARIZONA

Corazon Doyle
1515 East Osborn Road
Phoenix

Gilbert Sanchez
Director
Tucson-Southern Counties
Mental Health Services
P.O. Box 5481
Tucson

Julia Soto
721 North Fourth Street
Tucson

Martin Valles
917 East Washington Street
Phoenix

CALIFORNIA

Vince Camacho
16643 Ashland Avenue
San Lorenzo

Jose Flores
Department of Mexican American Affairs
Sacramento Dioceses
5890 Newman Court
Sacramento

Esperanza Garcia
Psychiatric Social Worker
University and Fifth Clinical Services
500 University Avenue
San Diego

Amalia Guerrero
Mental Health Community Worker
County Department of Mental Health
512 South Indiana Boulevard
Los Angeles

Luis Loera
Student, School of Social Work
President, MECHA
Member, Trabajadores
Sacramento State College
Sacramento

Celia Medina
Lecturer, School of Social Work
San Jose State College
315 South Ninth Street
San Jose

Isabel Naranjo
Mental Health Aide
Department of Social Welfare
Community Services Division
2815 "O" Street
Sacramento

Alicia Noriega
Social Worker
Los Angeles Mental Health Service
512 South Indiana Boulevard
Los Angeles

Herlinda Quintero
Community Mental Health Nurse
Los Angeles Mental Health Services
512 South Indiana Boulevard
Los Angles

Olga E. Terrazas
Student, School of Social Work
University of California
Berkeley

Marie E. Zuniega
Psychiatric Social Worker
Southeast Clinic
State Services Center
4235 National Avenue
San Diego

COLORADO

Rudy Garcia
Department of Mexican American Studies
University of Colorado, Denver Center
1100 14th Street
Denver

Delores Lucero
Caseworker I
Wazee Mental Health Center
Model Cities Program
1648 Wazee Street
Denver

Rubel Lucero (Deceased)
Program Director
San Luis Valley Mental Health Center
127 Washington Street
Monte Vista

Bernardo Lujan
1419 Mariposa
Denver

Gloria Martinez
Caseworker I
Wazee Mental Health Center
Model Cities Program
1648 Wazee Street
Denver

Orlando Martinez
Medical Social Consultant
Colorado Department of Public Health
4210 East 11th Avenue
Denver

George Solarzano
Psychotherapy Training Unit
Colorado State Hospital
1600 West 24th Street
Pueblo

Charles Tafoya
Social Worker II
Department of Psychiatry
Colorado State Hospital
1600 West 24th Street
Pueblo

Marcella L. Trujillo
Director, Mexican American Studies
University of Colorado, Denver
1100 14th Street
Denver

Uvaldo Valdez
Chicano Community Organization
of Boulder County
Boulder

NEW MEXICO

Margie Lovato
1717½ Gabaldon, N.W.
Albuquerque

Eloy Martinez
Chief Psychologist
New Mexico State Hospital
P.O. Box 1338
Las Vegas

Leo Romero (Deceased)
Coordinator
Bernalillo County Community Mental
Health Center
2600 Marble, N.E.
Albuquerque

TEXAS

Fred T. Adams
1080 Briarway
San Antonio

UTAH

Teddi Huntsman
2768 Carol Drive
Salt Lake City

Javier Saenz
Clinical Director
Group Therapy Program
Salt Lake City Mental Health Center
156 Westminister Avenue
Salt Lake City

WASHINGTON

Eloy Apodaca
Director
Chicano Institute
6217 N.E. Radford Drive
Seattle

Federal Staff:

Jeanette G. Nehren
Chief, Nursing and Related Theraputic Personnel Section
Division of Manpower and Training Programs
National Institute of Mental Health
Parklawn Building
5600 Fishers Lane
Rockville Pike, Maryland

Dr. Juan Ramos
Special Assistant to the Director Office of Program Liaison
National Institute of Mental Health
Parklawn Building
5600 Fishers Lane
Rockville Pike, Maryland

Arturo Raya
Special Assistant, Office of the Assistant Secretary
Health and Scientific Affairs
Room 4616, HEW North
330 Independence Avenue, S.W.
Washington, D.C.

Dr. Sam Silverstein
Experimental and Special Training Branch
Division of Manpower and Training Programs
National Institute of Mental Health
Parklawn Building
5600 Fishers Lane
Rockville Pike, Maryland

WICHE Commissioners

Bernard Baca, Superintendent
Los Lunas Consolidated Schools
P.O. Box 298
Los Lunas, New Mexico

John G. Mackie (Deceased)
Attorney
P.O. Box 147
Carbondale, Colorado

WICHE Mental Health Council

Robert A. Senescu, M.D.
Chairman, WICHE Mental Health Council
Chairman and Professor
Department of Psychiatry
University of New Mexico School of Medicine
Albuquerque, New Mexico

WICHE Staff

Dr. Robert Altman
Director
Special Higher Education Programs

Lu Anne Aulepp
Staff Associate
Improving Mental Health Services on Western Campuses

Leonard Baca
Special Education Program

Dr. James Banning
Director
Improving Mental Health Services on Western Campuses

Dr. Bernard Bloom
Consultant
Mental Health Continuing Education Program

Dr. James Bradshaw
Director
Special Education for the General Educator Program

Marie Branch
Director
Faculty Development to Meet Minority Needs

Helen Calvo
Project Secretary
Faculty Development to Meet Minority Group Needs

Bill Collard
Training Associate
National Center for Higher Education Management Systems

Raymond Feldman, M.D.
Associate Director, WICHE
Director, Mental Health Programs

Robert Hullinghorst
Director
Resources Development Program

Dr. Robert H. Kroepsch
WICHE Executive Director

Dr. Ben Lawrence
Associate Director, WICHE
Director, National Center for Higher Education Management Systems

Bruce J. Martin
Director
Correctional Manager Training Program

Richard Martinez
Director
Community College Mental Health Worker Program

Dr. Paul McCullough
Director
Western Conference on the Uses of Mental Health Data

Julia O'Rourke
Staff Assistant
Corrections Program

Paul Ries
Director
Nationwide Educational Programs for Institutionalized Children

Alfred L. Tate
Staff Associate
Nationwide Educational Programs for Institutionalized Children

Gerald Volgenau
Public Information Officer
Suzanne Young
Photographer and Information Assistant

Conference Secretaries

Mary Bessee
Secretary
Mental Health Programs

Carol Telfer
Secretary
Mental Health Continuing Education Program

Chicano Advisory Committee On Mental Health Continuing Education

Place: Boulder, Colorado

July 24-25, 1971

ARIZONA
Marco Duarte

CALIFORNIA
Alicia Noriega
Frank Quevedo

COLORADO
Vince Camacho
John Mackie (Deceased)
Gloria Martinez
Dolores Lucero

NEW MEXICO
Leo Romero (Deceased)

TEXAS
Narciso Aleman
Guadalupe Tamez

WASHINGTON
Eloy Apodaca

WICHE Staff
Kevin Bunnell
Stan Boucher
Ray Feldman

WICHE Commissioner
John G. Mackie (Deceased)

Chicano Plan For Mental Health— Pre-planning, Groundwork

Place: Albuquerque, New Mexico

September 10, 1971

Leo Romero (Deceased)
Coordinator
Bernalillo Community Mental Health Center
2600 Marble, N.E.
Albuquerque, New Mexico 87104

Tomas A. Villanueva
Route 1
P.O. Box 162 CA
Toppenish, Washington 98948

Ernest Ficco
Mental Health Administration
9107 Federal Office Building
1961 Stout Street
Denver, Colorado 80202

Pablo Delgado
Colorado Rural Legal Service
12 East 4th Street
La Junta, Colorado 81050

Armando Sanchez
Community Planning Specialist
County of Santa Clara Welfare Department
55 West Younger Avenue
San Jose, California 95114

Emma Chavirra, Community leader,
1506 8th N.W.
Albuquerque, New Mexico

Alicia Noriega
East Los Angeles Mental Health Center
512 South Indiana Boulevard
Los Angeles, California 90063

Sam Brito
Mental Health Consultant
Mental Health Administration
Region VI, NIMH, HEW
1114 Commerce Street
Dallas, Texas 75202

Mary Romero
943 Stanford N.E.
Albuequerque, New Mexico
87106

Eloy Apodaca
6217 N.E. Radford Drive
Seattle, Washington 98115

Javier Saenz
2787 E. 4510 South
Salt Lake City, Utah 84117

WICHE Staff
Stan Boucher
Linda Pauls

Planning Meeting

Place: Albuquerque, New Mexico

March 3-4, 1972

ARIZONA
Gil Sanchez
Executive Director
Tucson-Southern Counties Mental Health Services, Inc.
P.O. Box 5481
Tucson

CALIFORNIA
Jose Luis Flores
East Los Angeles Mental Health Center
512 South Indiana
Los Angeles

Amalia Guerrero
East Los Angeles Mental Health Center
512 South Indiana Street
Los Angeles

Robert Martinez
Community Organizer
4457 Telegraph Road
Los Angeles

Alicia Noriega
East Los Angeles Mental Health Center
512 South Indiana Street
Los Angeles

COLORADO

Stan Boucher
Director
Mental Health Continuing Education
WICHE, P.O. Drawer "P"
Boulder

Dolores M. Lucero
Caseworker
Denver General Hospital
130 W. 12th Ave.
Denver

Toby Maes (Deceased)
Program Aid
Denver General Hospital
130 West 12th Ave.
Denver

Gloria Martinez
Caseworker
Denver General Hospital
130 West 12th Ave.
Denver

Ignacio Rodriguez Jr.
Mental Health Consultant
18th & Stout
9244 Federal Bldg.
Denver

NEW MEXICO

Laura Martinez
United Child Care, Inc.
R.N., Counselor
Sol Edith Blvd. N.E.
Albuquerque

Leo Romero (Deceased)
Bernalillo County Mental Health Center
Crisis Unit Coordinator
2600 Marble N.E.
Albuquerque

Mary Romero
Mental Health Consultant
Primary Health Care System
816 Broadway S.E.
Albuquerque

TEXAS

Cruz Briones
Accounting Clerk
Student
Colegio Jacinto Trevino
P.O. Box 865
Mercedes

Francisco Briones
Director of Undergraduate Programs
Colegio Jacinto Trevino
P.O. Box 865
Mercedes

UTAH

Estella S. Hoagland
Psychatric Social Worker
Murray-Jordan Mental Health
4913 South Stute
Murray

Karol Pike
Spec. Ed. Teacher
Granite Mental Health Center
156 Westminster Ave.
Salt Lake City

Rosalie Pair
Health Coordinator
Utah Migrant Health Project
Utah Migrant Council
724 South 3rd East
Salt Lake City

Javier Saenz
Clinical Director
Group Therapy
Granite Mental Health Center
156 Westminster
Salt Lake City

WASHINGTON

Eloy Apodaca
Freelance Organizer
6217 N.E. Radford Drive
Seattle

Rubén Durán
Professor
Washington State University
Pullman

Richard A. Garcia
University of Washington
School of Social Work
14134 104th Place N.E.
Bothell

INITIAL DRAFTS: 5 TASK FORCE REPORTS

June 30-July 1, 1972

Place: Salt Lake City, Utah

ARIZONA

Corazon Doyle
1515 East Osborn Road
Phoenix

Gilbert Sanchez
Administrator
Tucson-Southern Counties
Mental Health Center
P.O. Box 5481
Tucson

SOUTHERN CALIFORNIA

Jose Duarte

Amalia Guerrero
East Los Angeles Mental
Health Center
512 South Indiana Boulevard
Los Angeles

Robert Martinez
Community Organizer
4457 Telegraph Road
Los Angeles

Alicia Noriega
Social Worker
East Los Angeles Mental
Health Center
512 Indiana Boulevard
Los Angeles

NORTHERN CALIFORNIA

Henry Lopez
Sacramento Concilio
Box 896
Sacramento

Efraím Lugo
294 California Street
Campbell

Quireno Parra
Sacramento Mental Health
Aid Service
2125 19th Street
Sacramento

Richard Rose
Sacramento State College
Teachers Corps Program for
Higher Education
5816 Keyntel Street
Citrus Heights

COLORADO

Dolores M. Lucero
Caseworker
Denver General Hospital
130 West 12th Avenue
Denver

Toby Maes (Deceased)
Program Aid
Denver General Hospital
130 West 12th Avenue
Denver

Francisco Martinez
Colorado Rural Legal Services
P.O. 569
Alamosa

Gloria Martinez
Caseworker
Denver General Hospital
130 West 12th Avenue
Denver

Ignacio Rodriguez Jr.
Mental Health Consultant
18th & Stout
9244 Federal Bldg.
Denver

Marta Sotomayor
2041 South Race
Denver

NEW MEXICO

Del Arellano
Mental Hygiene Clinic
Veterans Administration Hospital
2100 Ridgecrest
Albuquerque

Ricardo Baros
Chicano Studies
University of New Mexico
Albuquerque

Edward Esquibal
Las Cruces Mental Health Center
1501 N. Solano
Las Cruses

Frank Larrangaga
COPAS
1320 Agua Fria
Santa Fe

TEXAS

Cruz Briones
Edinburg Mental Health Clinic
Edinburg

Edelmiro Briseno

Domingo Bueno
Director
Child Advocacy Program
1506 S. W. 19th Street
San Antonio

Roel Cantu

Joel Martinez

UTAH

Estella S. Hoagland
Psych. Social Worker
Murray-Jordan Mental Health Center
4913 South Stute
Murray

Karol Pike
Spec. Ed. Teacher
Granite Mental Health Center
156 Westminister Avenue
Salt Lake City

Rosalie Pair
Health Coordinator
Utah Migrant Health Project
Utah Migrant Council
724 South 3rd East
Salt Lake City

Javier Saenz
Clinical Director
Group Therapy
Granite Mental Health Center
156 Westminster Avenue
Salt Lake City,

WASHINGTON

Eloy Apodaca
6217 N.E. Radford Drive
Seattle

Richard A. Garcia
University of Washington
School of Social Work
14134 104th Place N.E.
Bothell

OREGON

Sonny Montes
1932 Cedar
Forest Grove

IDAHO

Rubén Durán
Professor
Washington State University
Lewiston

WICHE Staff

Stanley W. Boucher
Director
Mental Health Continuing Education

Richard Martinez
Director
Community College-Mental Health Worker Program

Linda Pauls
Secretary
Mental Health Continuing Education

CONFERENCE ON FUNDING—AND FURTHER WRITING

August 12-13, 1972

Place: Seattle, Washington

ARIZONA

Gil Sanchez

CALIFORNIA

Henry Lopez
Alicia Noriega
Ricardo Ontiveros
Rudy Hernandez

COLORADO

Gloria Martinez

TEXAS

Francisco Briones

UTAH

Karol Pike
Javier Saenz
Estella Hoagland

WASHINGTON

Eloy Apodaca
Richard Garcia

REGIONAL OFFICES

Ignacio Rodriguez, Region VIII

Joe Hoffman, Region IX

Roberto Durán, Region IX

Sam Brito, Region VI

David Hanson, Region X

NIMH Representative

Valdemar Gonzalez

WICHE Staff

Stan Boucher
Linda Pauls

Planning Committee toward a Conference on A Chicano Plan for Mental Health

Place: Tucson, Arizona

December 18-19, 1972

ARIZONA

Gilbert Sanchez
Executive Director
Tucson-Southern Counties
Mental Health Center
P.O. Box 5481
Tucson

NORTHERN CALIFORNIA

Tim Quintero
Sacramento Concilio
Box 896
Sacramento

Vincent Camacho
Associate Planner
Chicano Planning Council, Inc.
425 W. Hedding St.
Suite 204
San Jose

Maria Garcia
California State University at
San Jose
School of Social Work
San Jose

Ricardo Ontiveros
Manpower Interagencies
Deganawidah-Quetzalcoatl University
P.O. Box 409
Davis

Armand Sanchez
Dean, School of Social Work
California State University at
San Jose
San Jose

SOUTHERN CALIFORNIA

Alicia Noriega
East Los Angeles Mental
Health Center
512 South Indiana Boulevard
Los Angeles

Maria Perez
COSSMHO
Narcotics Prevention Project
507 North Echandia
Los Angeles

COLORADO

Marta Sotomayor
2041 South Race
Denver

Sally Ruybal
Colorado Migrant Council
665 Grant Street
Denver

PACIFIC NORTHWEST

Eloy Apodaca
University of Nebraska
School of Social Work
Omana, Nebraska

UTAH

Javier Saenz
Clinical Director
Granite Mental Health Center
156 Westminster Avenue
Salt Lake City

TEXAS

Francisco Briones
Colegio Jacinto Trevino
P.O. Box 865
Mercedes

Regional Offices, HSMHA

REGION VI

Sam Brito
Mental Health Consultant
Mental Health Administration
Region VI, NIMH, HEW
1114 Commerce Street
Dallas, Texas 75202

REGION VIII

Paul Blank
Mental Health Consultant
18th & Stout
9017 Federal Building
Denver, Colorado

Ignacio Rodriguez Jr.
Mental Health Consultant
18th & Stout
9017 Federal Building
Denver, Colorado

REGION IX

Roberto Durán
Mental Health Services
Regional Office IX, HEW
Room 441 Civic Center
50 Fulton Street
San Francisco, California 94107

Joseph Hoffman
Associate Director
Mental Health Services
Regional Office IX, HEW
Room 441 Civic Center
50 Fulton Street
San Francisco, California 94107

NIMH

Floyd Martinez, Ph.D.
Inter-Agency Liaison Branch
National Institute of Mental Health
5600 Fishers Lane
Rockville, Maryland 20852

WICHE Staff

Stanley W. Boucher
Director
Mental Health Continuing Education Program

Linda Pauls
Secretary
Mental Health Continuing Education Program

Toward a Chicano Plan for Mental Health

June 13-15, 1973

Place:
Las Vegas, New Mexico

ARIZONA

John Benitez
Box 211
Marana

Tito Carrillo
La Frontera Center
Tucson

Miguel A. Gradillos
803 W. Calle Garcia
Tucson

Consuelo Juarez
367 W. Calle Garcia
Tucson

Socorro Meza
1880 W. Burgess
Phoenix

CALIFORNIA

Juan Alcedo
University of California
Medical Center
3rd Avenue & Parnasis Street
San Francisco

Angelo Alvarez
La Raza Drug Effort
508 11th Street
Sacramento

Vince Camacho
425 W. Hedding
San Jose

Victor Castillo
4457 E. Telegraph Road
Los Angeles

Roberto Castro
1248 Kewen Street
San Fernando

Miguel Durán
3626 E. 5th Street
Los Angeles

Roberto L. Duron
Mental Health Services
Regional Office IX, HEW
Room 441 Civic Center
50 Fulton Street
San Francisco

Maria Garcia
5831 Montevine Drive
San Jose

Joseph Hoffman
Associate Director
Mental Health Services
Regional Office IX, HEW
Room 441 Civic Center
50 Fulton Street
San Francisco

Henry Lopez
630-9th Street
Sacramento

Efraím Lugo
55 West Younger Street
San Jose

Ralph Maradiaga
729 Darmouth
San Francisco

Maria Elena Martinez
64 Scharff
San Jose

Robert Medina
601 S. Kingsley Drive
Los Angeles

Noel Morrell, M.D.
Stanford University Health Services
Menlo Park

Guillermo Negrete
12545 E. Cumarah Drive
Clovis

Alicia Noriega
512 S. Indiana
Los Angeles

Ricardo Ontiveros
85 Carlos Court
Walnut Creek

Maria A. Perez
COSSMHO
507 Echandia
Los Angeles

Gonzalo Puig
512 South Indiana
Los Angeles

Guadalupe Romo
310 22nd Street
Sacramento

Richard E. Rose
5816 Keyntel Street
Citrus Heights

Rudy Anthony Sainz
609 Bird
San Jose

Conchia Saucedo
814 York Street
Oakland

Dr. Arnold Solis
Mission Neighborhood Center
San Francisco

Socorro Zuniga
1722 J Street
Suite 14
Sacramento

Dr. Armando Morales, D.S.W.
Department of Psychiatry
School of Medicine
UCLA at Los Angeles
760 Westwood Plaza
Los Angeles

Eleanor Thonis
315 4th Street
Wheatland

COLORADO

Simon Cardenas
Denver General Hospital
8th Avenue and Cherokee
Denver

Arturo Cabrera
University of Colorado
School of Education
Boulder

Armando C. DeBaca
Denver General Hospital
8th Avenue and Cherokee
Denver

Willene Duran
4003 O'Neal Apt. 19
Pueblo

Dolores Lucero
5583 Pecos
Denver

Helberto Navarro
815 N. Albert
Walsenburg

Bob Nolasco
339 Galapago Street
Denver

Roberto Quiros
291 Falcon Drive
Pueblo

Ignacio Rodriguez
Mental Health Consultant
Region VIII
9244 Federal Office Building
18th & Stout
Denver

Sally Ruybal
Colorado Migrant Council
665 Grant Street
Denver
and American Academy of Pediatrics
2114 Central Street
Evanston, Illinois

NEBRASKA

Jose Arrieta
1621 So. 52nd Street
Omaha

NEW MEXICO

Dr. Frank Angel
President
New Mexico Highlands
University
Las Vegas

Jose Angel
Student Supportive Services
New Mexico Highlands
University
Las Vegas

Beatriz Apodaca
529 Atrisco SW
Albuquerque

Eloy Apodaca
529 Atrisco SW
Albuquerque

Margaret M. Aragon
1015 85th
Las Vegas

Del Arellano
VA Hospital
Albuquerque

Lorraine Campa
1618 Barelas SW
Albuquerque

Josie Candelaria
H.P.C.
Albuquerque

Andrellita Chavez
Box 102
Mora Route
Las Vegas

Cipriano P. Chavez
1418 9th
Las Vegas

Josie G. Chavez
2258 San Ignacio
Albuquerque

Rose Marie Chavez
Nosotros, Inc.
Las Vegas

William P. Chavez
807 Grant Street
Las Vegas

Larry S. Cockrell
130 Davis Drive
Las Vegas

Rob Colby
112 San Felipe NW
Albuquerque

Estaban De La Torre
New Mexico Highlands
University
Las Vegas

Dwight Duran
Juntos, Inc. & Nosotros, Inc.
Las Vegas

Loretta Duran
1622 7th Street
(Nosotros)
Las Vegas

George Esquibel
2600 Marble
Albuquerque

John Esquibel
NARA I & II
Albuquerque

Christine Esquivel
3827 4th NW
Albuquerque

Ignatio Flores
Plagge Memorial Center
Las Vegas

Dora Garcia
112 San Felipe NW
Albuquerque

Evans Garcia
112 San Felipe NW
Albuquerque

Miguel P. Garcia
Room 215
El Conquistador Hall
Las Vegas

Archie Garduno
Nostros, Inc.
Las Vegas

Belarmino Giron
State Capitol
Santa Fe

Lydia Gutierrez
1618 Barelas SW
Albuquerque

Annette Harrelson
Juntos, Inc.
621 Old Santa Fe Trail
Santa Fe

Doris Herrera
112 San Felip NW
Albuquerque

Alvin O. Korte
New Mexico Highlands
University
Las Vegas

Manuel Leqia
Route 1 Box 78
La Mesa

Linda Lopez
Dueseo
Albuquerque

Enos Lovato
LaLlave
Albuquerque

Irene Lucero
P.O. Box 612
Las Vegas

Joseph A. Lucero
College of Santa Fe
Santa Fe

Damian Lujan
Nostros, Inc.
Las Vegas

Jennie E. Maes
P.O. Box 301
Mora

Emma Maese
1501 N Solano
Las Cruces

Miguel Maestas
731 Lee Drive
Las Vegas

Bernadette Maldonado
418 Foothill Drive
Albuquerque

Antonia Martinez
2400 Yucca Drive
Las Vegas

Roberto Mondragon
Lieutenant-Governor
State of New Mexico
State Capitol
Santa Fe

Rita Montano
614 Jackson
Apt. 3
Las Vegas

Juan Montoya
409 Burma NE
Albuquerque

Juan J. Montoya
1602 New Mexico Avenue
Las Vegas

Raymond Montoya
Deseo
Albuquerque

Rita R. Mora
2600 Marble
Albuquerque

Alejandro Moralez
1190 Douglas
Las Cruces

Blanca Moralez
1501 N. Solano
Las Cruces

Juan Morfin
318 Astec
Santa Fe

Ricardo Moya
Duranes Health Clinic
Albuquerque

Mario Narro
1521 7th NW
Albuquerque

Rosario S. Novalis
Box 276-C
Montezuma Route
Las Vegas

Robert Ortega
322 56 SW
Albuquerque

Adelina Ortiz De Hill
P.O. Box 45
Santa Fe

Mike Padilla
1501 N. Solano
Las Cruces

Victor Padilla
9136 Guadalupe NW
Albuquerque

John Purcell
Plagge Memorial Center
Las Vegas

Betty Rael
112 San Filipe NW
Albuquerque

Jose Santiago Romero
P.O. Box 1103
Anthony

Maria Romero
P.O. Box 1103
Anthony

Mary Romero
Albuquerque Family Health Center
Albuquerque

Pat Romero
LaLlave
715 Grand SE
Albuquerque

Linda Romo
714 University
Las Vegas

Albert Sanchez
3514 Crest SE
Albuquerque

Flsie Sanchez
2909 Los Aringos Court #5
Las Cruces

Roberto Sanchez
Bernalillo County Mental
Health Center
Albuquerque

Sarah Sandoval
3640 Isleta SW
Albuquerque

Antonio Salon
1519 S. Gonzales
Las Vegas

Lila Solano
Sapello
New Mexico

Roberta Sosa
1501 N. Solano
Las Cruces

Ernesto Suazo
930 Stanford Drive
Albuquerque

Pete Tafoya
LaLlave
Albuquerque

Georgia Temorio
Juntos, Inc.
Las Vegas

Luis Torres
Juntos, Inc.
Las Vegas

Delfino Trujillo
New Mexico Highlands University
Las Vegas

Juan Trujillo
New Mexico Highlands University
Las Vegas

Pat Trujillo
6113 Kingston NE
Albuquerque

Roberto Trujillo
181 Bridge Street
Nosotros, Inc.
Las Vegas

Robert P. Udero
VA Hospital
225 Dallas NE
Apt. 3
Albuquerque

Leroy Ulibarr
P.O. Box 2171
Las Vegas

Jose Vasquez
1733 Del Norte SW
Albuquerque

Minnie Nuranjo
730 Woodland NW
Albuquerque

IDAHO

Rogelio Garza
415 8th Street South
Boise

Celia Longoria
716 W. Cedar
Pocatello

OREGON

Pablo Ciddio y Abeyta
306 NE Holman
Portland

Carlos De La Henga
1542 SE Malden Street
Portland

WASHINGTON

Pina Camarillo
420 N 6th
Walla Walla

Leo Cantu
W.F.W.S.F.
Granger

Francisco Cello
118 10th Avenue
Seattle

David Diaz
Farmworker Family Health Center
P.O. Box 390
Toppenish

Dr. Rubén Durán
Route 2 Box 303
Pullman

Richard Garcia
14134 104th Place NE
Bothell

David Hanson
Associate Regional Health Director
for Mental Health
Mental Health Administration,
Region X
Arcade Building Plaza
1321 Second Avenue
Seattle

Elda Mendoza
9611 24th N.W
Seattle

Al Ortega
3775 15th Avenue NE #305
Seattle

Dona Padilla
6175 NE Radford Drive
Seattle

Jose Rodriguez
Mental Health Administration
Region X
Arcade Building Plaza
1321 Second Avenue
Seattle

Jose Luis Villarreal
School of Social Work
University of Washington
Seattle

TEXAS

Hugo L. Ayala
Colegio Jacinto Trevino
Mercedes

Francisco Brions
Colegio Jacinto Trevino
Mercedes

Edelmiro Briseno
Colegio Jacinto Trevino
Mercedes

Sam Brito
Mental Health Consultant
Mental Health Administration
Region VI, NIMH, HEW
1114 Commerce Street
Dallas

Amelia M. Castillo
620 Castile Street
El Paso

Paz [illegible]ndo
Colegio Jacinto Trevino
Mercedes

George Garza
Colegio Jacinto Trevino
2518 Monterrey
San Antonio

Nasario Gres
Colegio Jacinto Trevino
2518 Monterrey
San Antonio

Joel Martinez
Colegio Jacinto Trevino
Mercedes

Grace Stearns
2200 Mountainview
Hurst

Guadalupe Tamez
P.O. Box 221
La Villa

UTAH

Robert Archuleta
978 Cheyenne Street
Salt Lake City

Clorinda Cordova
Four Corners Mental Health Center
P.O. Drawer "U"
Price

Estella Cordova
245 N. 1000 West
Provo

Socorro Duran
Westside Mental Health Center
Salt Lake City

Manuel Fernandez
Weber Mental Health Center
Ogden

Aurelio Garcia
Utah Migrant Council
46 West Utah Avenue
Payson

Bernadette Martinez
Murray-Jordan Mental Health Center
Murray

Karol Pike
Granite Mental Health Center
Salt Lake City

Javier Saenz
2787 E. 4510 South
Salt Lake City

NIMH

Oscar Allen
National Institute of Mental Health
5600 Fishers Lane
Room 13C-05
Rockville

Valdemar Gonzalez
Center for Study of Minority
Group Mental Health Program
National Institute of Mental Health
Parklawn Building
5600 Fishers Lane
Rockville

Dr. Floyd Martinez
Inter-Agency Liaison Branch
National Institute of Mental Health
5600 Fishers Lane
Rockville

Carlos Reyna
National Institute of Mental Health
5600 Fishers Lane
Room 13C-05
Rockville

WICHE

Stanley W. Boucher
Director
Mental Health Continuing
Education Program
WICHE
P.O. Drawer P
Boulder

Luis Medina
Director
Faculty Development-Minority
Content in Mental Health
WICHE
P.O. Drawer P
Boulder

Linda Pauls
Secretary
Mental Health Continuing
Education Program
WICHE
P.O. Drawer P
Boulder

Gerald Volgenau
Public Information Office
WICHE
P.O. Drawer P
Boulder

IMPLEMENTATION AND EDITORIAL COMMITTEE

March 15-16, 1974 **Place: Mt. Angel, Oregon**

CALIFORNIA

Efraim Lugo
Urban Barrio
55 West Younger Street
San Jose

Alicia Noriega
Addictions, Inc. Alcohlism
East Los Angeles Mental
Health Center
512 South Indiana Boulevard
Los Angeles

Ricardo Ontiveros
Migrants/Rural
321 Golf Club Road, Bldg. 25
Pleasant Hill

Maria Perez
Addictions, Inc. Alcoholism
Narcotics Prevention Project
507 North Echandia
Los Angeles

Arnoldo Solis, M.D.
Mission Neighborhood Center
450 Sutter
Suite 2141
San Francisco

IDAHO

Rogelio Garza
Idaho Migrant Council, Inc.
415 South 8th Street
Boise

NEW MEXICO

Sarah Baca
Centro Familiar De Salud
816 Broadway S.E.
Albuquerque

Vic Padilla
Bernalillo Community Mental
Health Center
2600 Marble Drive, N.E.
Albuquerque

OREGON

Pablo Ciddio
Colegio Cesar Chavez
Mount Angel

Jose Gallegos
Colegio Cesar Chavez
Mount Angel

TEXAS

Elsie Sanchez
Department of Health
Education, and Welfare
Regional Office
Office for Civil Rights
1114 Commerce Street
Dallas

UTAH

Karol Pike
Education and the Child
2137 Wislon Avenue
Salt Lake City

Javier Saenz
Granite County Mental
Health Center
156 Westminster Avenue
Salt Lake City

WASHINGTON

Rubén Durán
La Familia
Washington State University
Pullman

Donna Padilla
Washington-Alaska RMP
500 University Dist. Bldg.
Seattle

Regional Office Representatives

Roberto Duron
Regional Office IX, HEW
Room 441 Civic Center
50 Fulton Street
San Francisco

WICHE Staff

Stanley W. Boucher, Director
Mental Health Continuing Education
P.O. Drawer P
Boulder

Linda Pauls
Secretary
Mental Health Continuing Education
P.O. Drawer P
Boulder

Las Vegas: the audience listens to yet another proposal. Exhileration and tedium are constant companions at this kind of gathering.

GPO 830-285

Aunque estoy herido,
No estoy muerto.
Dejame descansar y sangrar un rato,
Y luego me levanto al combate en seguida.

— UN AZTECA ANÓNIMO

Los hermanos sean unidos,
Porque esa es la ley primera;
Tengan unión verdadera
En qualquier tiempo que sea,
Porque si entre ellos pelean
Los devoran los de afuera.

— JOSÉ HERNANDEZ